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ABSTRACT

The purpose of this project was to develop a methodology to establish standards of job performance and continuing education opportunities for maintaining competency of occupational therapists. The report contents include (1) Statement of the Problem (The Need for Re-Certification, Problems in the Design of the Re-Certification Program, and the American Occupational Therapy Association (AOTA) Continuing Certification Program); (2) Purpose and Scope of the Project; (3) Methodology for Establishing Standards of Job Performance in Specialty Practice Areas (Problems Encountered, Evaluation of the Methodology, and Recommendations for Revision and Refinement of the Methodology); (4) Methodology for Establishing Relevant Continuing Education Programs (Problems Encountered, Evaluation of the Methodology, Potential Applicability of the Methodology for Other Health Care Professions); and (5) Summary and Conclusions (Implications of the Contract Results and Analysis and Identification of Needs for Further Study). The appendixes include (1) AOTA Continuing Certification Program, (2) Project Time-Table, (3) AOTA Data Questionnaire (1973), (4) Task Force Members and Consultants, (5) Delineation of Roles and Functions in the Five Specialty Areas, (6) Selected Bibliography on Performance Evaluation and the Development of Standards, (7) Packet of Information on Peer Review, (8) Sample Data Abstract Form Used in Chart Audit Study, (9) Standards of Job Performance in the Five Specialty Areas, (10) Data Abstract Forms for Chart Audit/Record Review, (11) Knowledge and Skills Required of an Advanced Level Occupational Therapist Practicing within the Specialty Area of Mental Health, (12) A Self-Study Program for the Occupational Therapist as a Mental Health Practitioner, and (13) The OATA Proposed Continuing Education Plan. (HD)

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Contract No. NO1-AH-44116

The Final Report on the AOTA Continuing Competency Project:

A Project to Develop a Methodology to Establish Standards of Job Performance and Continuing Education Opportunities for Maintaining Competency of Occupational Therapists

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For:

Department of Health, Education, and Welfare
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PREFACE

This final report was prepared as partial fulfillment of the requirements of contract no. NO1-AH-44116 with the Division of Associated Health Professions, Bureau of Health Manpower, Health Resources Administration. This report covers the entire project which began July 1, 1974 and was completed August 31, 1976. The Project Director was Madelaine S. Gray, OTR. The Part 1 Principal Investigator was Sandra J. Leimer, OTR; the Part 11 Principal Investigator was Diane Shapiro, OTR.

The Project Staff would like to thank the task force members and the special consultants who were instrumental in the development of the standards of job performance and the continuing education methodology and materials. In addition, we would like to express our appreciation to the several hundred occupational therapists who served as reviewers of the standards and the continuing education materials and to the seventy-one therapists who participated in the chart audit study to evaluate the standards. Special thanks are expressed to the AOTA national office staff, especially Gail S. Fidler, OTR., Shirley Zamora, OTR., and Patricia C. Ostrow, OTR., the AOTA Continuing Certification Coordinating Committee, and to Robert Conant, Ph.D., the Project Officer for the assistance which they provided during the project.

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August 31, 1976

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A. Statement of the Problem

1. The Need for Re-Certification

The quality and increasing cost of health care services are of major concern to persons in the health care professions, the government, health related organizations and businesses, and the general public. One of the crucial questions is how consumers can be assured of receiving the quality of health care that is needed and deserved. Another question is how persons and organizations that pay health care bills can be assured that they are receiving the quality of services for which they are paying.

Answers to some of these questions can be found in research on the health care delivery system, the health manpower supply, knowledge and techniques of health care, and educational programs. Another answer to the question of quality control is that more must be done to ensure that those persons who are credentialed as health care practitioners are periodically re-credentialed on the basis of demonstrated competency.

At the present time in most health care fields, once a person has met the education, work experience, and/or examination requirements for entry-level licensure, certification and/or registration, his or her competency is rarely re-evaluated, except through unstandardized evaluations by the employer.

This problem is compounded by the fact that practitioners in many health professions can drop out of the work force for many years, and re-enter the profession as competent to practice simply because they have retained their credential through payment of annual licensure, certification or registration fees. A system for periodic renewal of credentials on the basis of demonstrated job competency is needed in order to provide more protection for the consumer, the employer and the reimburser.

2. Problems in the Design of a Re-Certification Program

Although most certification organizations for health care professions recognize the need for a re-certification system, only a few organizations have actually implemented a re-certification program. One of the principal problems or questions expressed by certifying organizations concerns the best way to measure and assure continued competency.

Many of the re-certification programs that have been implemented are designed on the basis of mandatory participation in continuing education programs; however, in 1967 the AOTA decided against a re-certification procedure based upon mandatory continuing education requirements. The evidence examined by the AOTA indicated that job competency can not be adequately measured through a system of collecting points or credits for attendance at approved conferences courses, workshops, and seminars. Continuing education programs can be used to help maintain job competency; however, evidence of having attended continuing education programs is no guarantee that learning has taken place, that job competency has been maintained or increased, or that quality of care is being provided.

Other procedures, such as written and oral examinations and simulated job testing, have been discussed, and in some cases, have been developed and implemented as the basis for re-certification. However, some of this pioneer work in the development of re-certification programs is now being questioned as to its suitability, effectiveness and/or efficiency in the assessment of competency. Written examinations can test cognitive skills and knowledge, but are no guarantee of the quality of actual on-the-job performance. Knowledge and skill demonstrated on an examination are not necessarily applied in the actual job situation. The written or oral examination can predict the ability to perform, but does not access actual on-the-job performance, which is the crucial issue. Likewise, simulated job testing can be very time-consuming, expensive, subjective, and except in highly technical fields, can not test the full range of expected job competencies.

Another problem is that an adequate and equitable system of re-certification should take into consideration the needs of specialized professionals. After entry-level certification as a generalist, most health care professionals become specialized practitioners, educators, and/or administrators in various speciality areas of a profession. Although advanced practitioners, educators, and administrators are expected to maintain certain core or generic areas of entry-level competency, they are not expected to maintain all entry-level knowledges and skills. For instance, the occupational therapist who has become a specialist in the area of psychiatry is expected to be able to demonstrate expertise in that speciality area and in the core knowledges and skills related to occupational therapy practice; however, this specialist in psychiatry is not expected to maintain all the entry-level knowledges and skills related to all other areas of practice such as physical disabilities or developmental disabilities.

Therefore, the problem of measuring job competency is compounded by the fact that an entry-level certification examination can not be used for measuring the competency of those individuals who have become specialized practitioners, educators, and administrators.

As long as an entry-level certification examination is reviewed and updated periodically to reflect current standards of practice as a generalist, it would be reasonable to use this entry-level examination as a mechanism for re-certifying those persons who choose to be re-certified as a generalist; however, different competancy assessment mechanisms must be available for those individuals who have become specialized practitioners, educators or administrators.

3. The AOTA Continuing Certification Program

For many years the AOTA has been working on a solution to these problems. In 1971, as a result of a resolution to the AOTA Delegate Assembly, the Continuing Certification Program was developed. Substantial progress has been made on this program and much of what the AOTA has already learned and accomplished has guided the development and implementation of this project. A description of the AOTA Continuing Certification Program and Resolution #300 is included in Appendix I.

The AOTA believes that it may be possible to design a re-certification program which is not only a more accurate assessment of job competency, but also takes into consideration the needs of specialized practitioners.

One such competency assessment procedure is the chart audit/record review procedure. In some health care fields, particularly medicine, chart audit procedures have been used on the local and state level for a number of years, and have been proposed as a mechanism for re-certification; however, no national professional association has had extensive experience in using chart audit/record review procedures for re-certification. Few guidelines are available for professional associations which are attempting to design a re-certification program based on the use of chart audit/record review procedures.

In 1973, a preliminary literature review indicated that standards of job performance must be available as guidelines if a chart audit and a peer review process were to be used to measure job competency and quality of care.

Research also indicated that if a re-certification program was implemented, there would be increased need and demand for continuing education programs which were easily accessible, not too costly, and relevant to job expectations and standards of job performance. Continuing education programs should be available as a learning resource, not as a requirement for re-certification.

Therefore, in 1974 the AOTA submitted to HEW, Division of Associated Health Professions, a contract proposal outlining a project to develop a methodology for the development of standards of job performance and continuing education opportunities which would help maintain the competency of occupational therapists. This project was viewed as the first step in building a competency-based re-certification program. A subsequent project would focus on the development of a chart audit/record review system for re-certification purposes. The contract was awarded and the project was conducted over a 26 month period, July 1, 1974 to August 31, 1976.

The next sections of this report contain a description of the specific purposes, methodology, and accomplishments of this project.

B. Purpose and Scope of the Project

1. Purpose of the Project

The objectives of this project were two-fold and were divided into two parts:

1) The objective of Part I was to:
   - develop a methodology for establishing standards of job performance in specialty practice areas

2) The objective of Part II was to:
   - develop a methodology for establishing relevant continuing education programs

Although the focus of the project was on the development of a methodology for establishing standards of job performance and continuing education programs for occupational therapists, the primary purpose of the project was to develop a generic methodology which would also be applicable to other health care professions.

Accomplishment of the Part I and Part II objectives would form the foundation for subsequent work on the design of a re-certification program using a chart audit/record review procedure as the competency assessment mechanism.

2. Scope of Work

The contract specified the following tasks for Part I:

"l) Develop a methodology for establishing standards of job performance for health care practitioners by utilizing the following procedures which shall be continuously assessed to determine feasibility as a generic model.

a. Five major areas of specialty practice shall be selected as the focus for the development of standards of practice. The criteria to be used in the selection of the five specialty areas include: the number of occupational therapists working in a particular area of practice; and the number and geographic distribution of expert practitioners and educators in the specialty area. Using these criteria, the specialty areas shall be selected from computer data on occupational therapy services according to client age categories, specific health conditions, and specific client work roles, such as the employee, homemaker and student.

b. Expert practitioners and educators in each of the five areas of occupational therapy practice shall be chosen as consultants and/or task force members. These candidates shall be selected by the project staff with assistance from members of the AOTA Council on Practice and the Council on Education. The task force for each specialty area of practice shall have five key members, assisted by a number of other members.

c. Special consultants with expertise in performance evaluation and the development of standards of performance shall also be retained to provide additional advice and guidance to the project staff.

d. The project staff, with the assistance of the consultants and task force members shall delineate the specialty roles and functions of occupational therapy in each of the five areas of specialty practice.

e. Consultants and members of the Council on Practice and Council on Education shall review and critique the delineation of specialty roles and fuctions, and revisions shall be made as needed.

f. The project staff, consultants, and task force members shall formulate a procedure for developing measurable standards of performance and shall prepare preliminary standards of performance for each of the selected specialty areas.

g. These preliminary standards shall be reviewed and critiqued by selected consultants and members of the Council on Practice and Education who are experts in the specialty area. The consultants and experts shall be asked to evaluate the extent to which:

1. the standards are measurable;
2. the standards are of adequate scope and depth to ensure a level of service adequate to meet client needs.

Revisions shall be made as needed."

The contract specified the following tasks for Part II:

"2) Develop a methodology for establishing continuing education opportunities which assist health care practitioners and educators to maintain and increase job competency. This shall be accomplished through studies conducted at the regional and national levels. Evolving procedures shall be continously assessed and revisions made where necessary to enhance the generic application of the model.

a. Regional Level Study

The focus is to develop continuing education programs at the local level. State affiliate association members will be trained to assess learning needs and assume the responsibility for developing and implementing their own continuing education programs. Implementation involves the following:

(1) Identification of a regional area, containing several state affiliate associations. Selection criteria includes: geographical location, transportation accessibility, membership numbers and distribution, and types of services provided. This information is available through computer data collected via membership questionnaires distributed in 1973.

(2) One of the five specialty areas of practice for which standards are to be established in Part I,

shall be selected for the development of continuing education programs. The following selection criteria shall be employed: the number of therapists represented by the specialty area and the continuing education needs of the therapists within the regional area. This information shall be obtained from the computer data described above.

(3) Consultants and task forces of expert practitioners and educators in the specialty area shall be selected from among the regional membership.

(4) Project staff, consultants, and regional task force members shall:

- identify the knowledges and skills required to perform the specialty roles and functions that were identified in Part I.
- develop self-assessment instruments which practitioners and educators can use to assess their knowledge and skills in the specialty area.
- identify available regional continuing education programs and resources in the specialty area;

and will subsequently identify additional programs and resouces which are not available.

- plan how to develop, obtain, and publicize the continuing education programs needed in the specialty areas. Local continuing education resources already available within academic and work settings will be utilized.
- implement the continuing education plan.

b. National Level Study

The focus is to develop continuing education programs at the national level. Although development of specialized regional programs is critical to continuing competency, more generic national programs are also essential.

One of the current problems with existing continuing education programs is that in many cases they are inaccessible to rural health care practitioners. Inaccessability, the time required away from work and financial costs are hardships for the rural and lower income area practitioner. Thus, the national level study focus is on the development of a variety of self-study materials which can readily be made available to rural as well as urban practitioners and educators.

The national level study will be implemented in the following manner:

(1) Selection of consultants, practitioners, and educators with expertise in the specialty area

(2) Identification of continuing education needs in the specialty area by means of a sample survey utilizing the self-assessment instrument developed in the regional study.

(3) Identification of the kinds of self-study materials needed based on the survey of continuing education needs.

(4) Development of indicated self-study guides and materials.

(5) Utilization of self-study materials by a sample group of practitioners and educators for purposes of evaluation.

(6) Distribution of self-study materials to practitioners and educators."

C. Part I Project:

Description of the Methodology; Problems Encountered; Evaluation of the Methodology; Recommendations for Revision and Refinement; Potential Applicability for Other Health Care Professions

The following information describes the work performed and the methodology used on the Part I section of the project conducted from July 1, 1974 to December 30, 1975.

Step I. Preparation of contract time-table:

a. description of the methodology:

The Project Staff estimated the length of time and sequence needed to perform each task specified on the contract scope of work. The estimation was figured on the basis of a monthly unit of time and was outlined graphically on a linear and vertical time-table.

The time table (Appendix II) indicates the proposed time sequence as well as the actual time sequence for the completion of the Part I and Part II projects. As is indicated in the timetable, some of the project activities were concurrent with each other.

b. evaluation of the methodology:

The contract time-table proved to be an invaluable guide for planning, coordinating, and measuring the progress of the project, as well as a useful reference to quickly and clearly orient other persons to the project plan and time factors.

Step 2. Selection of areas of practice: (scope of work item I.a.)

a. description of the methodology:

Initially, the Project Staff chose three speciality practice areas which focused on health conditions: mental health, developmental disabilities and stroke; and two speciality practice areas which focused on the therapist's employment setting: school systems and skilled nursing facilities.

One of the principal criteria used in the selection of the speciality areas was evidence of a high percentage of occupational therapists working in the speciality area. This information was obtained from the 1973 AOTA Data Questionnaire. (Appendix III)

Other principal criteria for the selection of the areas included: the known availability of expert occupational therapists and resource material in the speciality area, the anticipated future need for standards of practice in the area, and the expected future trends of occupational therapy practice.

Another guiding criterion was the need to develop standards which would be adaptable and flexible in the application to a wide variety of practitioners. Occupational therapists provide services to persons of all ages, with various types of health or learning problems, and in a variety of employment settings; therefore, the Project Staff attempted to identify those major factors or variables which would be a significant determinant of what type of services the client would need and the therapist should provide.

The major factors or variables identified were the: client's health condition, age, occupational role, and the therapist's employment setting. Initially, the Project Staff envisioned that standards could be developed in four modules, using one of the above mentioned factors or variables as the focus for each module. Each module would contain separate sets of standards. For instance, the health condition module would contain standards for each major health condition such as stroke, arthritis, spinal cord injuries, hand injuries, developmental disabilities, and mental health.

For the purpose of chart audit/record review, standards could be selected from each module, according to the client's health condition, age, occupational role, and the therapist's work setting. For example, if the client had a developmental disability, was eight years, old, was a student, and the therapist worked in a school setting, then the standards for each of these areas would be selected from each of the four modules. If the client had a stroke, was an elderly woman, who was a homemaker, and the therapist worked in a skilled nursing facility, then standards for each of these four areas would be used.

Since the Project Staff thought this modular approach was a useful idea, areas of practice were selected which related to two of the factors or variables: health conditions and work settings. The staff did not think it wise to also try to develop, within the relatively short period of contract time, standards according to age and occupational role factors.

The Project Staff discussed the selection of speciality areas with other members of the AOTA national office staff, the AOTA Continuing Certification Program Coordinating Committee, members of the AOTA Council on Practice, and the Division of Associated Health Professions.

b. problems encountered:

During the second quarter of the project, October to December 1974, the Project Staff changed the selection of speciality areas. The general areas of mental health, developmental disabilities, physical disabilities, and two specific diagnostic areas, stroke and arthritis, were selected and the work setting speciality areas were eliminated.

The new area, arthritis, was chosen on the basis of information from the 1973 AOTA Data Questionnaire which indicated that arthritis was a frequently encountered health condition. Stroke and arthritis are considered two sub-speciality areas of physical disabilities.

One of the reasons for the change in the selection of the speciality areas was that by choosing three global categories (mental health, developmental disabilities, and physical disabilities) and two sub-speciality areas, the Project Staff would be able to explore the usefulness of developing generic standards for all health conditions within a global category, as well as more specific standards for a particular diagnosis or problem area. Some overlap in each set of standards developed according to diagnostic conditions was expected; thus, this two-fold approach was expected to save costs, time and effort if the global standards could be used as the foundation for the development of the more specific diagnostic standards.

Another reason for the change in the selection of speciality areas was that the staff decided that standards developed according to health conditions could incorporate the other factors of age, occupational role and work setting. In addition, it was concluded that the amount of time, staff, and money required to develop standards for each major health condition, age category, occupational role and work setting would be present unwieldly problems. Also, it would be extremely difficult to develop standards for the age, role, and work setting modules that would not overlap with the health condition module.

Another factor that influenced the decision to change the speciality area selection was that the long range plan for the AOTA Continuing Ceritification Program is to re-certify persons working in speciality areas of practice. Although no decisions regarding speciality certification have been made, it is quite likely that re-certification would be available for direct service practitioners working in areas such as general practice, mental health, physical disabilities, and/or developmental disabilities. It is not likely that the AOTA would re-certify persons according to their place of employment, e.g. school system or skilled nursing facility. This type of re-certification would probably be too restricting in terms of career and geographic mobility, as well as potentially reducing the number of qualified personnel available to work in a given area.

c. evaluation of the methodology:

In retrospect, the Project Staff believes that the following methods were useful in selecting appropriate speciality areas of practice:

1) use of the data from the AOTA Data Questionnaire sent to all AOTA members in 1973. Having objective information about the types and number of employment settings and clients was an important element in deciding what speciality areas should be selected.

2) development of criteria for the selection of the speciality areas.

3) discussion of the selection of the speciality areas with other members of the AOTA national office staff, the Coordinating Committee and the Division of Associated Health Professions. It was useful to present and discuss the rationale for the selection of the speciality areas with persons not intimately involved in the project and/or the profession.

4) selection of speciality areas according to health conditions. Now that the Project Staff has more experience and expertise in the development of standards, we believe that it would have been too costly in terms of time, money and effort to

develop standards according to the original modular approach. In addition, it would have been hard to avoid overlap and duplication that probably would have made standards difficult to use and understand.

5) selection of general (e.g. physical disabilities) and diagnostic (e.g. stroke) speciality areas. It was a good decision to explore the usefulness of a combination of general and diagnostic standards. The Project Staff anticipate that the physical disabilities standards can serve as the general framework and baseline for the development of standards for additional diagnostic categories, e.g. spinal cord injuries, hand injuries, and cardiac conditions. Having the general baseline established should mean that only more specific details will need to be added for each diagnosis; thus saving time, costs and effort.

Since the stroke and arthritis standards are more detailed and specific, it is believed that they will be more useful for chart audit/record review purposes than the general physical disabilities standards. For this reason, occupational therapists may need to develop standards in more diagnostic areas for chart audit/record review purposes.

d. recommendations for revisions and refinement:

The Project Staff recommends no major changes in the methods used to select the areas of practice; however, within one of the methods used, (the development of criteria for the selection of the areas) it is recommended that the criteria not be developed until the long range purpose for the development of the standards has been clearly identified. The answers to such questions as: "Why are the standards needed?" and "How will the standards be used?" should help in the development of criteria for the selection of the areas of practice. For instance, if the standards are to be used as part of a re-certification program, it is important to carefully analyze what types of generalist and speciality certification will be available to the practitioners.

Step 3. Selection of occupational therapy practitioners and educators as task force members and/or consultants for the delineation of roles and functions and the development of standards of performance; selection of consultants with expertise in the development of standards of job performance and patient care evaluation studies. (scope of work items I.b. and c.)

a. desciption of the methodology:

The Project Staff selected the task force members and consultants on the basis of recommendations which were sought by mail, phone, or in person from members of the Council on Practice, national office staff, Coordinating Committee and well-known experts in the field. The list of task force members, consultants, and Coordinating Committee members is attached in Appendix IV.

At least four task force members were selected for each speciality area of practice. The criteria for the selection of task force members and consultants included: expert knowledge and skill in the selected area; experience in the development of standards; representation of a particular type of work setting and experience; ability to work in groups; interest and availability to work on the project. The ability to write concisely and clearly was an additional criterion for the occupational therapy consultants.

Whether or not a person met the criteria was determined largely by subjective judgements based upon knowledge of the person, experience in working with the person, publications, and discussions with the person.

Since not all task force members met all the criteria, the Project Staff also considered the composition of the task force in terms of a balance of expertise and abilities so that the task force as a whole met the criteria.

b. evaluation of the methodology:

The methods and criteria used to select the task force members and consultants were satisfactory. With few exceptions, the task force members and consultants worked effectively and efficiently; showed a commitment and interest in the project; accepted responsibility which required extra expense, travel, and work beyond their regular job responsibilities.

Although problems arose in some of the task forces, for the most part, the problems were due to the nature of the task itself rather than to the task force members.

c. recommendations for revision or refinement:

Although the criteria used for the selection of the task force members were satisfactory, it would have been beneficial to spend more time in an in-depth analysis of how well the person met the criteria.

Because the Project Staff felt the necessity to select the task force members within a limited period of time so that work on the project could begin, the staff spent only the equivalent of 2-3 weeks in identifying possible candidates, soliciting recommendations, analyzing the information, and contacting the candidates. If time permits, it is recommended that more in-depth information about the candidates' qualifications be sought from more people, i.e. each candidate's qualifications should be discussed at length with the candidate and several other persons.

Step 4. The delineation of roles and functions in each of the five speciality areas. (scope of work, items I.d and e.)

a. description of the methodology:

The primary purpose for delineating the roles and functions in each speciality area was that the delineation was expected to provide an initial frame of reference, foundation and guideline for the development of the standards of practice. The

Project Staff believed the delineating process would provide a necessary focus and beginning point for the development of the standards, and would help identify and clarify differences of opinion on the philosophy, theory, practice, and terminology used within the field of occupational therapy.

The definition of roles and functions was thought to be a prerequisite first step toward the development of standards. The Project Staff believed that until the job, the tasks, or the performance elements were identified, no explicit standards could be established to determine how well someone was performing his or her job. The assumption was that before statements could be made indicating "how well-quality", "how much -quality", "in what time", and "in what manner" a person is expected to perform a task, that the task must first be clearly identified.

During the first quarter of the project (July to October 1974), the Project Staff developed a plan to utilize three different methods to delineate the roles and functions. Once the project was completed, each method would be analyzed according to its effectiveness and efficiency.

The three methods to be used were:

1) On the basis of their own professional expertise and judgement, the task force members would delineate the roles and functions. These delineations would be sent to other expert therapists for review and critique. Revisions would be made as needed. The task force on skilled nursing facilities was to use this method.

2) The task force members would ask other expert therapists to identify the role and function of occupational therapy in the speciality area. This information would be obtained through a questionnaire developed by the task force. The results would be analyzed and the delineation prepared by the task force members. The task forces on mental health and developmental disabilities were to use this method.

3) On the basis of a selected literature review, the Project Staff would delineate the roles and functions. The delineation would be sent to the task force memebers and other expert therapists for review and critique. The Project Staff would revise the document as needed. The

task force on school systems and stroke would use this method.

As discussed previously in this report, the selection of the speciality areas was changed during the second quarter of the project. (October to December 1974). This meant that two of the task forces (school systems and skilled nursing facilities) were discontinued and two new task forces were formed (physical) disabilities and arthritis). Consequently there was not as much time available for the Project Staff and the new task forces to delineate the roles and functions and have the documents reviewed and critiqued as was originally planned.

At the time when the selection of the speciality areas was changed, the task forces on mental health and developmental disabilities had already sent questionnaires to several hundred occupational therapists. The intent of the questionnaires was to establish the parameters of occupational therapy practice in the speciality area as well as to begin to specifically define the functions of the occupational therapist practicing in the speciality area.

The mental health questionnaire was sent to 250 therapists working in the area of mental health. The 250 therapists were selected from a stratified sample of names obtained from a computer print-out based on the data obtained from the 1973 AOTA Data Questionnaire.

The developmental disabilities task force sent several questionnaires to expert occupational therapy practitioners and educators which the task force members selected.

In each case, mental health and developmental disabilities, about 50% of the questionnaires were returned to the task force members. The mental health task force had access to a computer, at no cost to the AOTA or the contract, thus they were able to put the questionnaire tabluations on a computer program.

Because of the shortage of time, the pressure to begin working on the standards, and the cost of task force meetings, the questionnaire results were turned over to the Project Staff who prepared the initial draft of the delineation of roles and functions in mental health and developmental disabilities. Another AOTA national office staff member in the Practice Division assisted in preparing the preliminary documents.

During the first quarter, the Project Staff began to identify literature to be used in a selected literature review on the role and function of occupational therapy in the treatment of stroke patients. In the second quarter, the Project Staff and the Practice Division staff member prepared draft documents on the role and function of occupational therapy in the areas of physical disabilities, stroke and arthritis, in addition to preparing the documents pertaining to mental health and developmental disabilities.

The delineations of roles and functions were organized according to the major processes of occupational therapy practice: evaluation, program or treatment planning, and program or treatment implementation. The major responsibilities within each of these three processes were identified based on the information obtained from the questionnaires, literature review, other expert therapists and/or personal expertise and judgement. In some areas, e.g. stroke and arthritis, specific treatment approaches or techniques were identified; however, for the most part, the delineation was rather general, allowing for greater freedom and flexibility in the choice of particular treatment methods.

In general, the delineation of roles and functions reflects a blend of actual and optimal occupational therapy practice. There was considerable debate over whether the roles and functions and the standards should reflect actual or optimal practice. This issue will be discussed in the next section dealing with the development of the standards.

All of the preliminary role and function documents were reviewed and critiqued by the Project Staff, other members of the national office staff, the task force members, and selected experts in the field. The task force members reviewed and critiqued documents in meetings and/or by mail. It was decided that the documents needed extensive revision in order to make the content more comprehensive, and to improve their clarity and readability. In order to do this, the Project Staff utilized consultants who were expert therapists in the speciality area and who were well-known for their ability to write clearly and concisely.

Each consultant worked a total of two to five days on reviewing, editing and revising the documents. No consultant was used in the area of mental health because the Principal Investigator for Part II and the mental health task force for the Part II project were able to satisfactorily delineate the roles and functions in mental health. The final documents are included in Appendix V.

b. problems encountered:

The Project Staff were unaware of the federal government requirement to have prior approval by O. M. B. of all questionnaries which are to be sent to more than nine persons. Since the questionnaires had already been sent, the solution to the probelm was to not charge to the contract any expenses related to the questionnaries.

Other problems were related to the amount of time which the delineation of roles and functions required on the part of Project Staff and task force members. The task force members were not able to meet frequently because of time and contract budget limitations. Having to rely on mail and telephone communications made collaborative thinking difficult.

In addition, the Project Staff and task force members did not know exactly what type of content, scope and depth, and format for the delineation of roles and functions would be the most useful as the foundation and framework for the next step of the development of the standards. Similarly, neither the Project Staff or task force members knew the best possible method to delineate the roles and functions. These "unknowns" about the nature of the product and the methods contributed to some disagreement and frustration on the part of the Project Staff and some of the task force members.

Another problem in some instances was the tendency for the Project Staff and some task force members to become self-invested in their work. On occasion, this made it difficult to accept and incorporate comments and suggestions from each other and from the reviewers. Considerable time and effort was spent in obtaining concensus in areas such as: technical terminology, definition of terms, and the inclusion or exclusion of controversial functions and techniques.

Some of the task force members were confused about the purpose and potential use of the delineation of roles and functions. Although it was explained that the purpose was to provide a frame of reference for the development of standards, many of the task force members were concerned that publication of the roles and functions would mean that it could be used for purposes other than the intended purposes. For example, they were concerned that the document could be used by the federal government and third-party payers to determine reimbursement for occupational therapy services, in malpractice suits, and in legislation requiring a definition of occupational therapy services.

As mentioned previously, there was considerable concern and discussion over whether or not the delineation of speciality area roles and functions should reflect actual practice or optimal practice. This problem arose because there appears to be some disparity between actual practice and optimal practice, and because there are philosphical differences about the type of occupational therapy services that should be provided. Although the Project Staff and consultants revised the delineation of roles and functions to reflect a blend of actual and optimal practice, they were reluctant to insist on drastic revisions on which the task force members emphatically could not agree or which were not reflected in any of the reviewers' comments Since the purpose of the delineation of roles and functions was to provide the task forces with a frame of reference for the development of standards of practice, it seemed unwise to insist on extensive content changes with which the task force members did not agree.

c. evaluation of the methodology:

The Project Staff believes too much time was spent on the delineation of roles and functions. The processes used, i.e. the questionnaire and the literature review, were probably not worth the costs in terms of staff and task force time and other expenses.

In addition, because of the concern that the documents would be submitted as part of the work produced on the contract, too much time and effort was spent making the documents suitable and satisfactory for publication and distribution. Although public education was not the purpose of the documents, because they were to be published as part of the final contract report and would therefore not be limited to internal and restricted use by the Project Staff, task force members and consultants, it became necessary to spend more time in making the documents as comprehensive, clear, and as readable as possible.

In terms of their usefulness to the Project Staff and task force members, the written documents and the process of delineating the roles and functions were of limited, short term value in relation to their purpose on the contract and the expense of time, effort and cost in producing them.

d. Recommendations for revision and refinement:

It would be of far greater value and less cost, to state from the begining of the project that although the roles and functions would need to be discussed by the task force members, only "in-house" notes should be made as needed for reference purposes. Since the standards should be distributed for extensive review and critique, there should be no need to also send the roles and functions for review and critique. Likewise, no documents on the roles and functions would be submitted as part of a report that would be published and made available for wide distribution within the profession that is developing the standards and/or to any other organization or agency.

Another possible approach would be to have consultants prepare an initial written draft of the roles and functions. This draft could be made available to the task force members for discussion purposes in order to assist them in thinking about the focus, scope, and content of the standards. It is recommended that consultants, rather than the Project Staff, prepare this initial draft document, unless the Project Staff themselves are expert in the particular speciality area.

Another recommendation concerns a question which the Project Staff later raised, "Is it absolutely necessary to define the roles and functions, before attempting to develop standards?" For instance, it might be just as useful to first define the expected outcomes of occupational therapy services, e.g. "What do you want the client to achieve as the result of your services?" From the answer to this question, it would be possible to move to the next question, "In order for the client to achieve this outcome, e.g. independence in performing self-care activities, what occupational therapy services should be provided?"

The next step of developing the standards would be to ask the question, "What evidence would you look for in order to determine if and how well that service had been provided (process standards) and if the client has achieved the expected outcome (outcome standards).

These questions will be discussed further in the next section of the development of the standards.

Step 5. development of standards of job performance. (scope of work item I.f. and g.)

a. description of the methodology:

1) review of literature:

The first step which the Project Staff undertook was a selected literature review on performance evaluation, the development of standards, and peer review.

The literature on performance evaluation and the development of standards which was found to be the most useful is listed in the bibliography in Appendix VI. A bibliography of selected literature on peer review is included in the packet of information on peer review, attached in Appendix VII. It is important to note that this was not a complete, in-depth literature review of all available material.

Other material which was reviewed included information from health care professional associations at the national, state and local levels. The Project Staff reviewed some of the standards that had been previously developed in the fields of occupational therapy, psychology, physical therapy, medicine, social work, and nursing.

Most of the standards which had been previously developed were process standards which did not specify the expected quality level of the task to be performed. Instead, the standards were a general description of the task to be performed, with very little indication of "how well," "how much", "in what time", or "in what manner", the task should be performed. It was more of a question of whether the practitioner performed the task or not, with no question about the quality of the task performance. For instance, a common type of standard was "the practitioner should document the treatment plan" or "should evaluate the client". This type of standard gives very little indication of the expected content of the treatment plan or evaluation. What is to be evaluated? What should the treatment plan include? How should the treatment plan be related to the evaluation results?

Some standards attempted to specify a quality level by stating that "an appropriate evaluation should be done", or that "the treatment plan should be appropriate". However, this type of qualifying adjective does not give much guidance to the person who must decide if an "appropriate" evaluation was done.

The Project Staff recognized some of the difficulties and dangers in developing standards which specified the elements of quality, quantity, time and manner; however, the staff decided that it would be advantageous to try as much as was feasible, desirable and realistic to include some of these elements into the standards. Inflexible and restrictive standards were naturally to be avoided; however, more specific standards which contained some indication of the expected quality level would be of more use in assessing the quality of practice. The degree to which to Project Staff and task force members were successful in this attempt to specify quality levels will be discussed in another section of the report.

2) discussion/workshop with consultants:

During the second quarter, the Project Staff met with the principal consultant, Dr. Brown. The process of developing standards was discussed and a workshop for the task force members was planned.

A 2 1/2 day workshop was held during the third quarter (January 1975). During this time, the two consultants (Brown and McConkey) assisted the Project Staff, the AOTA Practice Division staff member, and the task force members in learning the process of developing standards of practice. The process will be discussed in another part of the report.

3) meetings with task force members:

The task force members worked in small groups, according to their speciality area, e.g. standards for developmental disabilities. Four of the task forces had chairpersons previously selected by the Project Staff; one task force appointed their own chairperson.

The chairpersons were responsible for the work of the task forces and for communication with the Project Staff and Practice Division staff member.

The consultants held one workshop with the Project Staff and task force members. For the remainder of the project, (January to December 1975) the task forces held total group meetings with at least one member present from the Project Staff or the Practice Division. There was only one meeting of one task force that a staff member did not attend. Most of the task force members worked on the project outside scheduled total group meeting time. Some task force members worked individually and/or met with a few other task force members or other therapists on their own time and their own expense.

There was extensive reliance on mail and telephone communication in order to reduce travel and per diem expenses. All of the task forces met a least twice; most of the groups met four times; one task force met five times.

4) clarification of terms:

One of the initial steps in the process of developing the standards was to clarify new terms that were frequently being used by the consultants and Project Staff.

The following definitions were given to the task force members:

Standard - "something established by authority, custom or general consent as a model;for example, something established for use as a rule or basis for comparison in measuring or judging capacity, quantity, content, extent, value, or quality."

The type, model, or example commonly or generally accepted or adhered to; criterion set for usage of practice."

"A level of excellence, attainment, etc., regarded as a measure of adequacy."
Syn. -criterion, gauge, yardstick.[1]

"A statement which indicates how well, how much, in what time, and/or in what manner an individual is expected to perform a task."[2]

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[1] Guralanik, David B. (editor): Webster's New World Dictionary. The World Publishing Company, New York, N. Y. 1972

[2] Gray, M. "What are Criteria for Performance Objectives", Performance Evaluation, proceedings of a Training Institute, Bella J. May, Editor, Medical College of Georgia, 1973.

Comment: "Standards may already exist in the form of a job description or a list of tasks to be performed. Caution should be taken, however, to develop standards for the level of acceptable performance. The standards must be stated in measurable terms. They should be stated not only in terms of what is to be done but also in terms of how well it's to be done, how often, how much should be accomplished, and any other quantitative criteria."[3]

Structure Standards - "the appraisal of structure involves the evaluation of the settings and instrumentalities available and used for the provision of care. While including the physical aspects of facilities and equipment, structure appraisal goes far beyond to encompass the characteristics of administrative organization and the qualifications of health professionals."[4]

Process Standards - "the assessment of process is the evaluation of the activities of physicians and other health professionals in the management of patients, the criterion generally used is the degree to which management of patients conform with the standards and expectations of the respective professions. These standards and expectations may be derived from what is considered to be ideal, good, or acceptable practice as formulated by recognized leaders of the profession. Such standards may also be inferred from patterns of care observed in actual practice."[5]

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[3] "Cross-Reference", American Hospital Association. Vol. 3, No. 4 April, 1973.

[4] Donabedian, A.: "A Guide to Medial Care Administration, "American Journal of Public Health, Vol. II, New York, N. Y. 1969.

Outcome Standards - "assessment of outcomes is the evaluation of end results in terms of health and satisfaction.[6]

Quantity Standards - "refers to the how many, the how much, the number, the amount. It is generally best if quantity standards are stated as a range of acceptable quantity, rather than as an absolute amount.

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[5] Ibid.

[6] Ibid.

The following statements are examples of quantity standards:

1. writes 3-5 progress notes per week
2. evaluates 2-5 patients per week
3. attends 60-80% of all case conferences within the Rehabilitation Department
4. performs passive ROM exercises at least 5-15 minutes per day with each assigned bedside patient
5 writes 1-3 treatment plans per week
6. evaluates, plans and implements treatment programs for 25-30 patients per month."[7]

Quality Standards - "refers to the how well, the appearance, the accuracy, the error rate, the results obtained.

The following statements are examples of quality standards:

1. no more than 5-10 errors in every 25 muscle strength evaluations
2. treatment plans are sufficiently accurate; the instructor makes fewer than 4 changes in each treatment plan

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[7] Gray, op.cit.

3. the student makes few errors in teaching patient dressing techniques. The student is corrected no more than 3 times

4. written reports, treatment plans, progress notes are written so legibly and neatly that not more than 5 out of 100 must be redone

5. at least 75% of the time, patients are able to follow the student's direction. Patients do not make mistakes, become confused or irritated because of the student's instructions

6. student establishes sufficient rapport with patients so that few patients complain about the student's manner or attitude

7. no patient is ever seriously harmed by what the student does."[8]

Time-standards - "refers to the how soon, the time within which the task should be started or completed. Again, it is usually best to state the time as a range, rather than as an absolute amount.

The following statements are examples of time standards:

1. within 24 hours of receipt of patient referral, the student has reviewed the patient's medical chart, and has completed an initial interview with the patient

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[8] Ibid.

2. treatment plans are completed within 2 days after evaluation is completed

3. initial evaluation note is written in patient's record within 3 days after receipt of referral

4. all accident reports are submitted to supervisor within 2 hours after accident has occurred."[9]

Method Standards - "refers to the manner in which the task should be done, or the method which should be used, or how the task should be performed.

The following statements are examples of method standards:

1. the student writes legibly

2. the student speaks clearly and distinctly enough to be easily understood

3. the student uses the Denver Developmental Test battery to evaluate the child's level of development

4. the student always locks the brakes on the patient's wheelchair before transferring him from wheelchair to bed

5. follows standardized procedures for evaluating ROM as outlined in the procedures manual."[10]

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[9] Ibid.

[10] Ibid.

5) discussion of process vs. outcome standards:

From the very beginning of the project there was extensive discussion on the advantages and disadvantages of developing process standards vs. outcome standards.

One of the problems with the process-oriented approach is that it may allow the quality assessment process and the re-certification program to lose sight of the main target - the client. Instead of focusing on the ultimate goal, the client's benefit from the service, the process - oriented approach focuses on what kind of services the client receives. Another potential disadvantage to process standards is that they may tend to stifle creative experimentation and research with new treatment methods.

On the other hand, outcome standards are difficult to state in such a specific manner that it can be clearly and easily determined that the client did or did not achieve the expected outcome. In order to be usable, the outcome standard must be stated in such a way that the therapist can document evidence of the client's achievement of the outcome.

If the therapist does not or can not document what the client achieves, then the chart auditor can not identify if the outcome standard was achieved. Accordingly, the use of outcome standards requires that a therapist must learn a different type of documentation; e.g. the documentation of outcomes rather than process.

Another problem arises over the question of the relationship between the client's non-achievement of an outcome and the therapist's lack of competency. Since many variables can affect the outcome, e.g. client's motivation, financial status, family relationships, types and degree of health problem and age, and since there is not sufficient research evidence on the relationship of client achievement of outcomes and practitioner competency, it would be difficult to deny re-certification to a therapist whose clients do not achieve outcome standards.

This same problem holds true for the use of process standards as the basis for re-certification. Without sufficient research evidence, who is to say that therapists who do not met the process standards are less competent and should be denied re-certification? On the other hand, one of the merits in the process approach appears to be that since process standards are statements of what occupational therapists consider to be good or quality occupational therapy practice, it would seem to follow that a therapist who is not providing these quality services should not be re-certified.

This discussion of process vs. outcome standards points to the fact that the AOTA must be extremely careful in the design of the re-certification program. The re-certification program must use policies and procedures which protect the consumer, are fair to the therapist, and are legally defensible.

Therefore, until solid research evidence is available on the relationship of process and outcome to job competency, one approach to re-certification could be to establish a policy that re-certification will be given to those therapists who are satisfactorily participating in an on-going quality assurance program using a combination of process and outcome standards in a chart audit/record review program. Guidelines and procedures could be developed to identify satisfactory participation in a quality assurance program.

In summary, the Project Staff, and most of the task force members, consultants, and the Coordinating Committee members agreed that since one of the principal purposes of this project was to explore and develop a methodology for the development of standards, that we should attempt to develop both process and outcome standards. Also, since we were not sure what type of standards would be useful for re-certification purposes, we concluded that the development of both types of standards could be helpful in eventually making a decision on what types of standards would be useful in a re-certification program.

6) discussion of actual vs. optimal practice standards: Another decision that had to be made during the development of the standards concerned the question

of whether the standards should reflect actual practice or optimal practice.

While there was a strong desire to help improve the quality of care by developing high standards, there was also a concern for the practitioner who will be trying to meet the standards. Until there are enough continuing education resources which are relevant, of reasonable cost, and easily accessible, it does not seem reasonable to expect practitioners to provide services which they have not been trained to provide.

Although the AOTA standards for accredited educational programs reflect optimal occupational therapy practice, the therapist who will be participating in the re-certification program will have graduated from an education program at least five or more years ago. This means that although educational programs have continually updated their programs to reflect optimal practice, therapists may not have had the same oppotunity to do so, except through local continuing education programs.

Participation in graduate education is beyond the financial resources of many practitioners.

Another reason for not developing optimal standards at this time is due to a concern that if the standards do not appear reasonable and achievable to the practitioners, the practitioners will be reluctant to participate in the re-certification program.

After discussion of these points, a decision was made to try to develop standards which reflect an acceptable level of practice rather than an optimal level of practice. Since the intent is to periodically up-date the standards as practice improves, the standards should gradually reflect optimal practice.

7) The identification of characteristics which the standards should have:

With the assistance of the two consultants during the workshop meeting, the Project Staff and task force members determined that the standards should have the following characteristics:

- relevant
- understandable
- measurable
- behavioral
- achievable

During the time which the Project Staff and the task force worked on the standards, the standards were periodically reviewed to determine how well they were meeting these characteristics. Revisions were made accordingly.

8) Preparation of initial draft of the standards:

The basic method which the Project Staff and task force members used was group discussion with at least one person recording significant points on a flip chart or other paper. No specific group process techniques such as brainstorming or the Delbecq technique were used.

Although there were differences in the dynamics of the group, the task forces basically used the same procedure, with some variations in terms of sequence.

The general procedure used for the development of the process standards was as follows:

a) the qualities of "good" practice were identified, i.e. everything that a therapist should or should not do for a given client was listed; from this list, the most essential and critical tasks that a therapist must or should perform were identified.

b) these tasks were grouped according to the categories of the total process of practice; in occupational therapy, these categories were evaluation, program planning, and program implementation.

c) the tasks were arranged sequentially within each category.

d) the list of tasks was reviewed; duplications were deleted; missing tasks were added.

e) as much as possible, the tasks were written so that the task statement included an indication of how well, how much, in what manner, and/or in what time the therapist was to perform the task. In some cases, these elements were not included in task statements because of a concern that the standard would be too rigid.

Technically, a standard does not have to have these elements. It can be sufficient to simply state the standard as a task that must be performed, i.e. "the therapist must document the treatment plan". This type of standard is measured by simply determining if the therapist performed the task. However, as stated previously, this type of standard does not give any guidelines for determining whether the treatment plan was well done or not.

f) the standards were reviewed by the task force members and staff to determine if the standard had the desired characteristics of being relevant, understandable, measurable, behavioral, and achievable. Revisions were made as needed.

The general procedure used for the development of the outcome standards was as follows:

a) the problems which were common and which required occupational therapy services were identified.

b) the goals or objectives were stated in relation to each problem. These goals became the expected outcomes.

c) the expected outcomes were grouped into categories related to the over-all goals of practice. For instance, in occupational therapy, the expected outcomes were grouped into categories such as "independence in self care performance", "improvement in motor functioning".

d) as much as possible, the expected outcomes were written so that the statement included indication of how well, how much, in what manner, and/or in what time the client was to achieve the outcome. Again, like the process standards, this was not done for all outcome standards, because the task force members thought the standards would be too rigid or would not always be applicable to all clients.

e) the standards were reviewed by the task force members and staff to determine if the standards were relevant, understandable, measurable, behavioral, and achievable. Revisions were made as needed.

It is important to note that in the early stages of the project, the staff and task force members were relatively unskilled in these procedures; therefore, some of the steps were performed more successfully than others. The next step of having other therapists critique the standards proved to be an extremely important and valuable method of identifying errors, missing items, areas of confusion, as well as areas of agreement.

9) critique of the standards by other therapists:

As each task force completed the initial draft of the standards and all subsequently revised drafts, the standards were sent to other therapists for critique. The task forces used the following procedures for selecting therapists to critique the standards:

a) the selection of expert therapists who were known personally by the task force members.

b) the selection of therapists who were well known for their expertise in the speciality area, but who were not necessarily known personally by a task force member.

c) the selection of therapists who were members of a special interest group, e.g. the developmental disabilities special interest group.

d) the selection of therapists who identified themselves as being in the speciality area, e.g. mental health. This information was obtained from a computer print-out based on data available from the 1973 AOTA Data Questionnaire.

e) the selection of therapists who responded to a notice in the AOTA Newsletter, indicating that any interested therapist may critique the standards.

The therapists who were asked to critique the standards received the following items in addition to the standards: a letter of orientation to the project, the deadline and instructions for the critique, a glossary of terms, and a stamped, self-addressed return envelope.

For the most part, the reviewers responded on time and with many comments. The request seemed to be favorably received and the therapists were quite willing to assist.

10) analysis of the reviewers' critique, revision of the standards as needed:

The critique, analysis, and revision phase of the development of the standards was a continuous, cyclical process from

March to December 1975. The critiques were analyzed and revisions made by the staff and/or task forces. In some cases, the critiques were returned to the staff, who reviewed them and sent the comments to the task force members for their use either individually or at the next task force meeting. In some instances, the staff revised the standards and sent them to the task force members for review and comment. In other cases, each member of the task force or the chairperson received the critiques and was responsible for summarzing the comments in preparation for the next task force meeting to revise the standards.

During the last review period, August - October 1975, over two hundred reviewers returned their critique of the standards to the Project Staff for review, analysis and revision.

In general, the reviewers' comments were quite favorable; however, there were many suggestions for revisions of content, terminology, format and organization. Many reviewers felt that the standards would be extremely useful as guidelines for planning new programs, educating other health care personnel about occupational therapy, and for assessing the quality of the occupational therapy program.

II) critique of the standards through a chart audit study:

a) pilot chart audit study:

From March to July 1975, the only method used to evaluate the standards was an "arm chair" review of the standards by other therapists. The reviewers critiqued the standards on the basis of their own knowledge, expertise, and judgement.

Toward the end of this review period, the Project Staff discussed the possiblity of conducting an empirical review, asking therapists to use the standards as they were intended to be used in a record review or chart audit program. The Project Staff met with one task force and planned a small, pilot chart audit study using one set of the standards.

The four members of the task force reviewed, or asked other staff members to review, a minimum of ten records or charts.

For the purpose of the chart audit study, the Project Staff developed a data abstract from which the therapists could use to record whether the standard was met or not met, and to record whether the therapists thought the standard was relevant, understandable, measurable, behavioral, and achievable.

The task force members summarized the comments obtained from the pilot study and the standards were revised at the next task force meeting.

The results of the pilot study indicated that chart audit was a useful procedure for identifying areas of confusion, inaccuracies, and duplication.

b) chart audit study with all the standards:

After the pilot chart audit study was concluded in September 1975, the Project Director requested and received approval for a three-month contract extension in order to conduct a full-scale chart audit study with all the standards.

No additional contract funds were requested, because the Project Staff believed the study could be conducted within the existing contract budget. Costs were held to a minimum by relying on mail and telephone communication. No individual or group meetings were held with any of the task force members or any other participant in the chart audit study.

Prior to the development of the pilot and the full-scale chart audit studies, the Project Staff collected information on chart audit procedures and developed a packet of information on peer review procedures. (Appendix VII) Another staff member who was responsible for the AOTA -PSRO program, assisted the Project Staff in gathering information on the development of standards and chart audit procedures. The PSRO staff member also worked with another consultant, Dr. Donald Dennis, who had extensive experience in designing medical care evaluation studies.

All of the standards were converted into a data abstract format, similar to the one used in the pilot study. The data abstract form included the standards, and a section to be used to evaluate each standard. One of the data abstract forms used in the chart audit study is attached in Appendix X.

The Project Staff used the following criteria to select therapists to participate in the study: experience with chart audit procedures; experience with the development of standards, and/or recognized expert practitioner in the speciality area.

A total of forty-two therapists were asked to participate in the study. Some therapists received standards for more than one speciality area and were asked to select additional staff members to participate in the study. In this way, each set of standards would be evaluated by a minimum of ten therapists. Each therapist was asked to review a minimum of three charts.

The therapists received a letter orienting them to the study, a set of instructions with a 10 day return deadline, the standards, the data abstract forms, a stamped, special delivery, self-addressed return envelope, and a stamped, self-addressed reply card indicating whether or not they would participate in the study. The therapists were also instructed to call (collect) the Project Director if there were any questions; however, only four persons called.

A total of seventy-one therapists participated in the study; 117 data abstract forms were returned for review and analysis by the Project Staff. A few therapists did not have time to participate in the study and some therapists were able to complete only one or two data abstract forms. The lack of full participation was probably due to the short amount of time available for the study (10 days) and the fact that the study was being conducted right before the holiday season. Due to problems in mail delivery, some therapists did not receive the material until after the deadline date for return of the data abstract forms.

The Project Staff reviewed, summarized, and analyzed the comments received on the standards. The standards and the data abstract froms were revised accordingly. Because the standards were to be included in the final report for the Part I section of the contract, there was not sufficient time to return the standards to the task force members for their comments and recommendations; however, this was done at a later date.

The standards will be submitted to the AOTA Delegate Assembly for their approval. Approval by the Assembly will make the standards official AOTA standards.

b. problems encountered:

One of the primary problems encountered was a tendency on the part of the Project Staff and task force members to lose sight of the fact that one of the reasons for conducting the project was to develop a methodology for the development of standards of job performance. There was a tendency to focus more on the development of the product rather than on the process. Although attention was paid to the process, the Project Staff and task force members did not utilize a standard procedure for recording and evaluating the process. Although the Project Staff and task force members were able to document what process was used, it would have been useful to summarize and document at regular intervals the process that had been used during each stage of the project.

A related problem was that some task force members expected concrete, specific instructions on how to develop the standards, instead of realizing that one of the purposes of the project was to develop such a methodology. When neither the consultants nor the Project Staff gave detailed, specific instructions, some task force members became frustrated with what seemed to them as a lack of direction. Although this was a problem in the intital stages, each task force was able to overcome this problem and complete their tasks.

Some other problems arose bacuse of a lack of clarification and understanding regarding the respective roles of the task force members and the Project Staff. Whereas the Project Staff viewed the task force members as being instrumental in the initial development of the standards, the Project Staff did not view the task force members as having the ultimate responsibility for the content, format and terminology of the standards. Because the Project Staff were responsible and accountable for the contract work, they viewed themselves as necessarily having the ultimate responsibility for the quality of the work performed on the contract. On the other hand, some of the task force members viewed the task force as having the ultimate responsibility for the standards. Some members felt that since they were selected for their expertise in the area, then they, as the experts, should have the final authority. Some of the task force members felt the Project Staff were making changes in the role and function documents and the standards simply at their own discretion.

One the other hand, the Project Staff in addition to feeling first-line accountability for the project, also felt that since they were reviewing and analyzing the comments received by hundreds of therapists, that they (the staff) were able to make reasonable revisions of the role and function documents and the standards. If time and contract funds would have permitted more task force meetings, it would have been desirable to have all revisions made or reviewed by the task forces; however, time and budget constraints did not allow for this in all stages of the review and revision process.

Some of the other problems encountered were related to the difficulty in developing specific, but non-rigid process standards. In some cases, the quality elements of performance were incorporated into the standards, but in other instances this was not possible because the standard would be too inflexible.

Similar problems arose in developing the outcome standards. For the most part, the outcome standards were general, rather than specific, because the staff and the task forces had great difficulty in stating the outcome standard in such a way that it would be achievable for most clients and measurable.

The chart audit results indicated that most of the outcome standards were not measurable. Therefore, in the final version of the standards all the outcome standards, except those for arthritis, were eliminated.

Other problems were due to the divergent points of view regarding the theory and practice of occupational therapy. Some therapists ascribe to the medical model of occupational therapy practice, others ascribe to a health/education model. These different perspectives accounted for some conflicts over whether the standards should reflect an emphasis on services for the reduction of pathology or an emphasis on services to increase the client's ability to function in his or her occupational role and environment. A compromise solution was to try, as much as possible, to incorporate both points of view; however, because the standards are categorized according to health conditions, some therapists may automatically assume on the basis of their first impression that the standards reflect only the medical model perspective.

A few problems were encountered with the full-scale chart audit study. One problem was the short amount of time (7-10 days) available for the therapists to review the charts and to return the data abstract forms. Consequently, some therapists were not able to participate or were only able to return one or two data abstract forms.

Another problem in relation to the chart audit study concerned the method used to record the therapists' reactions to the standards, i.e. to indicate whether the standard was relevant, understandable, measurable, and achievable. Some therapists did not clearly understand the terms.

Another problem was that the column used to record the therapist's reaction to the standard was placed on each page of the data abstract form itself; therefore, some therapists became confused over what they were supposed to evaluate. In some cases, the therapists tried to record their evaluation of the chart content rather than the content of the standard itself.

c. evaluation of the methodology:

The process and procedures described in sub-steps one through eleven (page 42-72) were useful in producing the desired results: the exploration and development of a methodology to develop standards of performance; the actual development of standards of performance in five speciality areas of occupational therapy practice.

There were a number of problems encountered, as outlined in the preceding section of the report; however, for the most part, the problems were satisfactorily resolved.

The ultimate determination of the effectiveness of the methodology and the quality of the standards will be the degree to which other persons and/or groups can satisfactorily use the methodology, and the degree to which the standards are accepted and used by occupational therapists. Naturally, this will have to be determined at a later point in time.

d. recommendations for revision and refinement:

The Project Staff recommends that the following refinements be made to enhance the methodology:

1) if consultants are used to conduct a workshop on the process of developing standards, have the consultants prepare a written outline of instructions which the Project Staff and task force members can use during and after the workshop.

2) if task forces are used to develop the standards, obtain concensus on the respective roles of the task force members, task force chairperson and the Project Staff. The areas of responsibility and

authority and the lines of communication should be mutually understood.

3) if task force meetings are held, always have one person present who represents the group which is responsible for planning and coordinating the development of the standards. Otherwise, unless detailed written reports are received from the task force, it is difficult for the Project Staff to be fully informed about the task force's work.

4) if task force meetings are held, explore the use of specific group process techniques such as brainstorming and the Delbecq technique.

5) if task forces are used to develop standards, provide written instructions for the development of the standards, provide written examples of standards, and send each task force copies of the standards being developed by all the other task forces. The Project Staff should

frequently review and critique the standards as they are being developed.

6) if other practitioners and educators are asked to review and critique the standards, request them to return their comments with their full name and address attached. This allows for an easier process of sending a follow-up letter of appreciation to the participants in the review process. The follow-up letter is probably an important element in maintaining the degree to which participants will be willing to take part in further studies.

7) if a chart audit study is conducted to evaluate the standards, use a separate form for the evaluation of the standards; do not incorporate the evaluation form into the data abstract form used for the record review or chart audit. Define the terms used to evaluate the standards, i.e., the terms "relevant", "measurable", "understandable", and "achievable".

8) if a chart audit study is conducted, allow a minimum of three weeks for the receipt and return of the materials. Allow the participants to use the client's overall record/chart, as well as the therapist's internal, departmental records.

9) if a chart audit study is conducted, ask the participants to indicate terms not understood; make suggestions for changing any standard with which they do not agree or do not understand. Ask them to not only indicate where changes are needed, but also to recommend what the change should be. Ask for specific suggestions for wording/terminology.

The Project Staff also has the following comments regarding future contracts:

1) The monthly reports were more useful to the Project Staff than quarterly reports. This reporting change was made in the third quarter of the contract and proved to be very helpful. The Project Staff also

suggests that the contract specify that the monthly report include copies of all work in progress, even though it is in draft form. This may be useful to the Project Officer in obtaining a clearer picture of the direction of the work in progress.

2) Depending upon the nature of the contract, it might be useful for the Project Staff, the Project Officer and other associated contract staff to have the Project Staff give an oral presentation of the contract work on a 3-month interval basis and/or at the conclusion of the contract.

Step 6. Consideration of the Potential Applicability of the Methodology to Other Health Care Professions

The Project Staff believes the following summarized steps of the methodology would be useful and applicable to individuals and associations representing other health care professions:

a) prepare a project time-table

b) select areas of practice for the development of standards

c) select practitioners, educators and/or other experts as task force members and/or consultants to develop the preliminary standards

d) review selected literature on the development of standards and record review/chart audit procedures

e) conduct an orientation and training workshop for the task force members or consultants to learn the process of developing standards

  - clarify terms
  - discuss and obtain concensus on the respective roles and functions of task force members, consultants, and administrative staff
  - discuss and decide if process and/or outcome standards will be developed
  - discuss and decide if the standards will reflect actual and/or optimal practice
  - identify the characteristics which the standards should have
  - discuss the roles and functions of the practitioners and the expected outcomes for the client
  - practice writing standards

f) prepare initial drafts of the standards and data abstract forms

g) conduct a pilot and full chart audit study to evaluate the standards

h) revise the standards as needed

Detailed descriptions of the procedures used within each of the above steps and recommended revisions and refinements are contained in preceding sections of this report.

The standards of job performance which can be developed by following the above methodology are designed to be used in a self-assessment, peer review and/or re-certification program. Those health care profession groups or associations which desire to utilize standards for these purposes should be able to apply the methodology, as long as the health care profession has the following characteristics:

1) the majority of personnel are direct service practitioners

2) the practitioners document their services regularly and in sufficient detail that the documentation accurately reflects the service provided

3) the practitioners' documentation is available in some retrievable form for self-assessment and/or peer review purposes.

D. Part II Project:

Description of the Methodology; Problems Encountered; Evaluation of the Methodology; Recommendations for Revision and Refinement; Potential Applicability for Other Health Care Professions

The following information describes the work performed and the methodology used on the Part II section of the project conducted from January 1, 1975 to August 31, 1976. The information is keyed to the contract scope of work.

The objective of the Part II project was to develop a methodology for establishing relevant continuing education programs. The project was divided into two studies: a regional level study which focused on the development of continuing education programs at the regional level; a national level study which focused on the development of continuing education programs at the national level.

1. Description of the Methodology; Problems Encountered

a. Regional Level Study:

The focus of the regional level study was to develop continuing education programs at the local level. (scope of work item 2.a)

Step 1) Identification of a regional area, containing several state affiliate associations (scope of work item 2.a. (1)).

The northeastern region including all the New England states and New York was selected as the geographical focus for the regional level study for the following reasons:

a. approximately 24% of the total of occupational therapists practicing in mental health reside in the northeastern region. This represents one of the three regions of high concentration.

b. Of these three regions, this region contained the greatest number of occupational therapist curricula. Many university facilities and faculty members would be available as resources for the project.

c. Travel between AOTA and the major cities in the northeast would be relatively efficient.

Step 2) Selection of one of the five speciality areas for the development of continuing education programs. (scope of work item 2.a.(2))

The speciality area of mental health was chosen for the focus of the continuing education project because:

a) a large proportion of occupational therapists work in the mental health field.

b) there was a lack of continuing education programs offered in mental health, as compared with the number of those offered in physical rehabilitation and developmental disabilities. The number and categories of programs announced in the AOTA Newspaper were tabulated for a six month period. There were fewer in mental health than in other areas. Queries regarding continuing education received by the AOTA office confirmed this conclusion.

c) on the 1973 AOTA Data Questionnaire, a large proportion of occupational therapists selected mental health-related topics as their first choice through fourth choice for continuing education programs.

d) knowledge and skill in the mental health area of practice would contribute to other major areas of occupational therapy practice. Continuing education programs designed for mental health practitioners should be valuable to occupational therapists practicing in other fields.

Step 3) Selection of expert practitioners, educators and consultants in the speciality area. (scope of work item 2.a. (3))

The therapists were chosen on the basis of their expertise in the speciality area and in the development of continuing education programs. The selection was made after discussion with members of the Council on Education, Council on Practice and other members of the AOTA national office staff. The list of regional level task force members and consultants is included in Appendix 1X.

Step 4) Identification of the knowledges and skills required to perform the roles and functions in the speciality area. (scope of work item 2.a. (4))

The regional level task force members began this project by reviewing the statement of "The Role and Functions of an Occupational Therapist as a Mental Health Practitioner" and the task inventory developed under the auspices of contract NO1-AH-24172.[11] The Project Staff and task force members translated the role and functions into knowledge and skills.

Although problems were encountered in trying to state the knowledge and skills in quantifiable terms for self-assessment purposes, the final document on knowledge and skills (Appendix X1) was used as a reference for the next step of the project, the development of the content of the self-assessment instrument.

Step 5) Develop self-assessment instruments which practitioners and educators can use to assess their knowledge and skills in the speciality area. (scope of work item, 2. a. (4))

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[11] AOTA, The Final Report on the Project to Delineate the Roles and Functions of Entry-Level Occupational Therapy Personnel in the Detail Needed to Serve as the Basis for the Development of Proficiency Examinations. Contract NO1-AH-24172; June 1973.

After much discussion and study of a variety of approaches, the Project Staff and the task force members decided to design a self-assessment instrument that would assist occupational therapists in identifying their skill in occupational therapy evaluation of patients/clients. The three case study examples and accompanying questionnaire (contained in Appendix X11) are the final version of the assessment instrument that was used. The design was successful in that it served to confirm our concern regarding therapists' lack of sophisticated skill in the evaluation process.

Prior to use of the self-assessment instrument, the Project Staff obtained critical problem data, collected by the faculty of Ohio State University, to assist in deciding upon direction and format. The Ohio State University occupational therapy faculty asked occupational therapists to identify specific problems encountered while on the job. The Project Staff earmarked the problem inventories completed by occupational therapists who were mental health specialists.

The responses from that sample were similar to those obtained from a group of generalists. Most of the respondents indicated management issues as critical. The data did not help in the design of a continuing education program, but did help the Project Staff, consultant and task force members realize that a self-assessment instrument must be carefully structured to identify specific needs.

The Project Staff ruled out the option of designing a forced choice, branching-type paper and pencil examination for assessment. That approach, to insure validity would have required the employment of the services of a testing agency. The estimation of time and money was too large for the scope of this contract.

The case-study self-assessment instrument was mailed to 200 occupational therapists in the northeastern region who indicated in the 1973 AOTA Data Questionnaire, specialization in the field of mental health. Announcements of the project was submitted to all the state affiliate newspapers to inform therapists about the project and to invite them to participate in the self-assessment study. In addition, the Project Staff contacted the affiliate presidents and curriculum directors asking them to acknowledge the importance of the project and encourage members and clinical faculty to participate.

A total of eleven completed instruments were received. A number of others were incomplete and several had been completed by therapists working in child psychiatry. The Project Staff realized that it was impossible to justify an interpretation of the data based upon such a small response; however, the content of the responses received did indicate specific problems related to the evaluation of patient/client function and differences in opinion regarding the role of the occupational therapists in the area of mental health.

The role of the occupational therapist as reported by the respondents was varied, often not clear and frequently not consistent with the role as described in "The Role and Functions of an Occupational Therapist as a Mental Health Practitioner". The task force members and Project Staff have observed in their positions as consultants and faculty that this is a frequent problem. Facilities use occupational therapy services quite differently and the expectations of occupational therapy programs vary greatly. Oftentimes the occupational therapist's role overlaps with the role of other activity-type mental health professionals

Information from other sources, e.g., 1976 reports from the AOTA Mental Health Task Force and the American Occupational Therapy Foundation research seminar, allowed the Project

Staff to generalize the findings of the self-assessment instrument; therefore, the Project Staff concluded that important goals of a continuing education program would be to: improve the ability of the occupational therapist to evaluate patients/clients; and to clarify the role of the occupational therapist in the area of mental health.

Step 6) Identify available regional continuing education programs and resources in the speciality area; and identify additional programs and resources not available. (scope of work item 2.a.(4))

The Project Staff conducted a study in the regional area to identify ongoing continuing education programs available to occupational therapists specializing in the area of mental health. Occupational therapy curriculum directors, affiliate associations and continuing education coordinators were contacted. No one could identify any programs being offered to occupational therapists specializing in mental health. Interdisciplinary programs were available but none specifically to meet the continuing education needs of occupational therapists in mental health. This finding reinforced the belief that there was a need to provide assistance to affiliate associations and other groups interested in providing continuing education programs.

Step 7) Plan how to develop, obtain, and publicize the continuing education programs needed in the speciality area. (scope of work item 2.a.(4))

The Project Staff with the assistance of the task force members developed a framework for a continuing education program to be administered nationally and regionally. The proposed plan is in Appendix XIII. The plan is a general plan and does not address itself to mechanics of publicizing the programs, obtaining speakers or facilities. The Project Staff concluded that the mechanics of the plan must be worked out on a more individualized basis, depending upon the nature of the program, the geographic location of the program and the lines of communication within the affiliate association membership.

Step 8) Implement the continuing education plan. (scope of work items 2.a.(4))

The proposed continuing education plan was presented to the AOTA Executive Board for discussion. The Board suggested that funds be sought to support the implementation of the continuing education plan. The proposed plan was then submitted to the American Occupational Therapy Foundation and subsequently the Foundation developed a continuing education grant proposal which has recently been submitted to 13 foundations.

The Part II Principal Investigator also initiated the presentation of a resolution to the AOTA Delegate Assembly, requesting the establishment of an Office of Continuing Education in the AOTA national office. In April 1976, the Delegate Assembly approved this new position and a person has been hired to develop and implement a continuing education plan.

b. National Level Study:

The focus of the national level study was to develop self-study materials which can be made available from the national level to rural as well as urban practitioners and educators. (scope of work item 2.b)

Step 1) Selection of consultants, practitioners, and educators with expertise in the speciality area. (scope of work item 2.b. (1))

The task force members were selected according to the same criteria and process described in the regional study. The list of the national level task force members is attached in Appendix IV.

The Project Staff continued to work with the regional level consultant; therefore, no additional consultant was selected.

Step 2) Identification of continuing education needs in the speciality area by means of a sample survey utilizing the self-assessment instrument developed in the regional study. (scope of work item 2. a. (2))

The delay in the development of the self-assessment instrument in the regional level study caused a time problem in the use of the self-assessment instrument on a national basis. In addition, the minimal data returned on the self-assessment instrument indicated significant problems with the instrument. It took therapists too much time to complete the assessment and the open-ended nature of the instrument yielded general rather than specific identification of continuing education needs.

Had there been more time and if the need had been critical to the accomplishment of the project's objectives, the self-assessment instrument would have been modified and distributed nationally; however, the Project Staff and the regional and national level task force members agreed that they had sufficient information from other sources; e.g., the Ohio State University problem inventory, the AOTA Mental Health Task Force report, the American Occupational Therapy Foundation research seminar report, to be able to identify continuing education needs in sufficient scope and depth for the purposes of this project.

Step 3) Identification of the kinds of self-study materials needed based on the survey of continuing education needs. (scope of work item 2.a.(3))

The Project Staff and task force members designed a series of continuing education programs. The first part of the series, the develoment of audio-tape cassettes, would be completed as part of this contract. The other segments of the series would be suggested as part of the AOTA continuing education program plan.

The proposed series of continuing education programs in mental health would include:

Focus of the Series:	Method to be Used:
clarification of role of occupational therapists practicing in mental health	audio-taped demonstration of occupational therapists collaborating with inter- and intra-disciplinary colleagues
orientation to occupational therapy principles of evaluation, program planning and program implementation	audio-taped demonstration of an occupational therapist's evaluation of a patient/client and presentation of planning for that patient/client
indepth experiences in the use and design of occupational therapy evaluation tools	programmed instructional packets, possibly in an audio-taped and textbook combination
orientation to and experience in use of peer supervision programs. This can be designed to reinforce study of evaluation principles	an outline of topics and issues for discussion with focussed questions. Groups can be given tasks to then be reviewed by experts

A pre and post self-assessment instrument should be designed to evaluate the effectiveness of the series. If the materials are found to be successful, a similar format could be developed for topics concerned with treatment/program planning and treatment/program implementation.

Step 4) Development of indicated self-study guides and materials (scope of work item 2.b.(4))

The Project Staff and task force members planned the content for the audio-tape cassettes. Scripts were written and several preliminary taping sessions were conducted before the final tapes were made. The content of the tapes focused on the role of the occupational therapist in mental health and on the occupational therapy evaluation of a patient. The role of the occupational therapist was demonstrated through the taping of an occupational therapist's presentation and discussion in an interdisciplinary team conference. The occupational therapy evaluation of a patient was demonstrated through an oral presentation to the team members.

The third part of the tape consists of an actual peer supervision session. This was included to demonstrate how occupational therapists can assist one another in developing proficiency in their functions. Although this session was spontaneous, the participants deliberately tried to address themselves to the use of activities in the treatment of the patient.

A self-study program guide was developed to be used in conjunction with the tapes. The guide contains the actual evaluation instruments discussed in the tapes, as well as instructions and supporting materials. The self-study program guide is attached in Appendix X11.

Step 5) Evaluation of the self-study materials by a sample group of practitioners and educators. (scope of work item 2. b. (5))

The task force members asked several occupational therapists to review the taped program and to assess its value as a continuing education program. The sample included advanced level occupational therapist mental health practitioners, educators, an entry level therapist working in mental health, and one occupational therapy student intern. In addition to reviewing the materials, they were asked to suggest methods for distribution and use of materials on a national level (see Step 6).

In the interest of time, the data was collected via telephone interview. The following is a synthesis of their general comments on the value of the program:

a) Without exception, all reviewers thought the material was excellent and would be important for occupational therapists specializing in mental health.

b) Some reviewers thought the taped presentation was too long and should be shortened. Others suggested that the case conference (first part) could be summarized.

c) A few reviewers suggested the tapes could be more beneficial if a transcript of the tapes was included in the study guide.

d) Several reviewers thought that the material would be especially helpful to occupational therapists who have not been practicing for several years and are now returning to mental health practice.

The following is a summary of specific suggestions for change in the taped and written material:

a) The case study self-assessment program should be rearranged so that the "experts" comments follows each case instead of separating the cases from the comments.

b) A statement should be included in the introduction of the written material to specify that the approach taken was based upon the judgment of the authors and that it is not necessarily the only approach possible.

c) The tapes material should be outlined and the speakers should be identified. Some reviewers reported that it was difficult to follow the taped presentation.

d) The self-study program should be shortened. Completion of the total program required between 6 and 10 hours

e) Even though the material was prepared for the advanced level therapist, the educator/reviewers thought that it could be used in basic professional programs as well. One of the reviewers has requested permission to use the material in a course next semester.

Step 6) Distribution of the self-study materials to practitioners and educators. (scope of work item 2.b.(6))

The audio tapes and the self-study program guide will be made available at cost to any interested therapist. The AOTA is also exploring the possiblity of establishing a tape-cassette and study guide loan library. Announcements of the availability of the self-study materials will be made in the American Journal of Occupational Therapy, the AOTA Newspaper, the AOTA Publications list, and in a letter to affiliate presidents.

The reviewers (see Step 5) suggested the following plan for distribution of the taped program:

a) The availability of the programs should be announced in the AOTA Newspaper with the suggestion that the program used by groups of occupational therapist, mental health specialists. A leader* of each group should request a complete set. The leader should also receive guidelines for preparing a study seminar.

b) The group leader should charge the participants a fee to cover the cost of duplication, mailing and room rental, if necessary. At an initial meeting, the pre-study section of the self-study program should be completed and collected by the leader.

c) The participants should divide into pairs and listen to the tapes, in three or four sessions. When completed, each should fill out the post study section of the self-study program and submit it to the leader.

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* The leader should be an occupational therapist educator or someone who can present comparable qualifications.

d) The leader should prepare a structured seminar based upon the pre and post study forms. The goals of the seminar should include identification of further study for the group and for individuals.

e) The leader should then assess the total program and prepare a report to be submitted to the AOTA, Coordinator of Continuing Education. The report should be used as a guide for development of future programs.

2. Evaluation of the Methodology; Recommendations for Revision and Refinement

The following section of the report contains a summary of the evaluation of the methodology and recommendations for revision and refinement.

The assumption behind the original design of the continuing education project was that therapists needed to be able to specifically identify their continuing education needs. The hypothesis was that a self-assessment instrument, designed on the basis of knowledge and skills to practice in the speciality area, would assist therapists in identifying their learning needs.

Sequentially, the project used the following steps to design the self-assessment instrument:

1. delineation of roles and functions

↓

2. identification knowledges and skills

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3. development of the self-assessment instrument

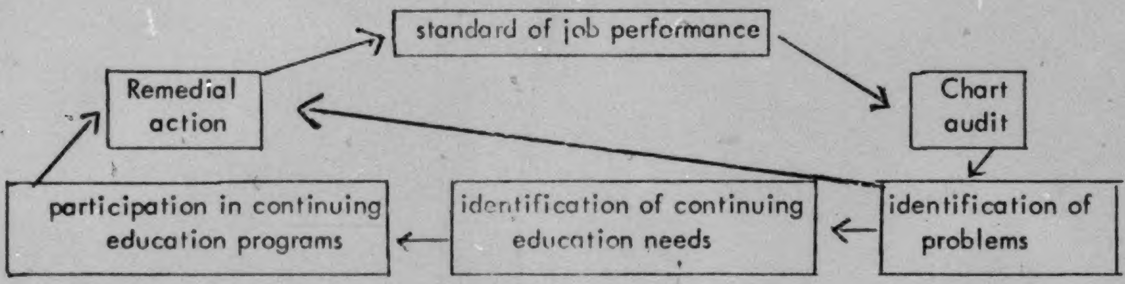
In retrospect, the Project Staff and task force members would not recommend such as approach. A self-assessment instrument, designed in this manner, does not yield sufficiently concrete or specific information to be useful to therapists in identifying their learning needs. The Project Staff and task force members are in agreement that for practitioners in direct service an assessment program through a chart audit and peer review process would be much more useful in identifying learning needs.

On the other hand, the Project Staff and task force members would recommend the development of tape cassettes and study guides to meet continuing education needs. Once continuing education needs are identified through the chart audit process, the tape cassettes and study guides could be a useful resource. The preliminary evaluations of the tapes and study guide developed on this project indicated that an audio taped program can be an effective method of continued education.

Since the tapes and study guides can be easily shipped, are not costly to produce, and require little extra equipment, they can be useful to the rural as well as urban practitioners and educators.

Once the AOTA continuing education plan is in operation, the regional continuing education coordinators can develop an information system which will yield data to the AOTA national office concerning the continuing education needs being identified through the local quality assurance programs.

The local quality assurance programs should have the following component process:


standard of job performance
Chart audit
identification of problems
identification of continuing education needs
participation in continuing education programs
Remedial action

3. Potential Applicability for Other Health Care Professions

This methodology with the recommendations for revisions and refinement noted in section 2, could be applied by other health care professions. The methodology would be particularly applicable to those professions which require their practitioners to document their services in some type of record, e.g., the medical chart.

Much work still must be done to design the chart audit process so thatit can be specific in the identification of continuing education needs; however, the chart audit process holds much promise for assisting health care practitioners in specifically identifying the strengths and deficits of their health care skills.

E. Summary and Conclusions

1. Implications of the Contract Results

With the conclusion of this two year project, the gound work has been established for the development of a re-certification program for occupational therapists. Standards of job performance have been developed to be used in a chart audit process and a method for developing relevant and accessible continuing education programs has been identified. The methodology used to develop the standards of job performance and continuing education programs can be used within the AOTA as well as other health care professions.

Since the objectives of the Part 1 and 11 projects were achieved, the AOTA Continuing Certification Program can proceed as planned. The implications of the project are that the AOTA will need to design:

a. the quality assurance process to be used in the re-certification program; including
    1) the use of the standards of job performance
    2) the chart audit process
    3) the procedure for identification of deficit areas
    4) the procedure for identification of continuing education needs

5) the continuing education program

6) the identification of remedial action that needs to be taken

b. the policies for the re-certification program.

The quality assurance program must be designed so that it is consistent with the PSRO program. Practitioners must not be expected to duplicate efforts or to participate in two types of quality assurance programs.

2. Analysis and Identification of Needs for Further Study

During the course of this project, the Project Staff and task force members identified the following areas that need to be studied further:

a. the development of inter-disciplinary standards of job performance. This may be useful to promote more collaboration and less duplication of effort by health care practitioners.

b. the development of academic and clinical education programs to teach the chart audit and peer review process.

c. the further development of coordinated regional and national level continuing education programs. Therapists participating in the local quality assurance programs could provide feedback to the regional continuing education coordinators who could work with the national office continuing education staff.

d. the effect of a quality assurance program on the quality and costs of health care.

e. the development of process-outcome studies to determine the relationship between the type of care given (process) and the outcome the client achieves.

The Project Staff and task force members have welcomed the challenge of this two year project and have appreciated the opportunity to participate in the efforts of the AOTA and the federal government to improve the quality of health care.

APPENDIX I

AOTA Continuing Certification Program

The American Occupational Therapy Association, Inc.

Received: February 15, 1971
Executive Board: February 1971
Delegate Assembly: April 28-29, 1971

RESOLUTION #300-71

TOPIC: CONTINUING CERTIFICATION AND REGISTRATION

ORIGIN: COUNCIL ON STANDARDS - AD HOC COMMITTEE ON CONTINUING CERTIFICATION AND REGISTRATION

WHEREAS, educational standards have been carefully determined, defined, and implemented to provide a mechanism whereby individuals who successfully complete the requirements for certification and registration are recognized as being competent and capable of providing occupational therapy service at the time of initial entry into the profession; and

WHEREAS, granting of certification or registration acknowledges the right to practice, and such right cannot be withdrawn except by due process proving breach of moral or ethical standards; and

WHEREAS, there is growing concern nationally among professional associations, employers, employing agencies, consumers, and regulatory bodies about the maintenance of qualifications to practice beyond the point in time at which one is initially certified, registered, or licensed; and

WHEREAS, the Delegate Assembly of the American Occupational Therapy Association has recognized this concern as it applies to occupational therapy and has acted to see that as a professional body the members of the American Occupational Therapy Association take the initiative to develop, maintain, and enforce such standards; and

WHEREAS, the development, implementation, and maintenance of standards for continuing certification and registration must necessarily be based upon:

1. the definition of "quality practice" in occupational therapy;

2. the development of criteria to evaluate quality practice at various levels of function;

3. the development of available and accessible educational opportunities to enable occupational therapists to maintain and increase their knowledge and skill so they can continue to provide quality services;

4. the development of educational programs to inform consumers and employers about the basic constituents of quality occupational therapy services;

5. the creation of groups, knowledgeable with due care and selection in hiring and related state laws, to work with local employers, attorneys, state certifying boards, and others to encourage employers to accept association and affiliate standards for quality programs and qualified occupational therapy personnel;

6. the education of occupational therapists toward understanding and participation in peer review and evaluative collaboration with others;

7. the development and adoption by both the American Occupational Therapy

Association and affiliate associations of a viable ethics clause which can be enforced.

8. the development of alliances with national, regional and state accrediting bodies to promote accreditation of occupational therapy service programs.

THEREFORE, BE IT RESOLVED, that the American Occupational Therapy Association initiate the three phase program as presented with modification as deemed appropriate to operate within the Bylaws, and

BE IT FURTHER RESOLVED, that an annual report be made to the Delegate Assembly to assist in determining the continuation or modification of the program.

PHASE I: (data collection, development of a plan of action to involve the American Occupational Therapy Association headquarters staff, councils, affiliate associations, and appropriate committees in the initiation of a study of the issues involved in the establishment of standards for continuing certification and registration as follows:)

1. Selection and hiring of an AOTA staff member to plan, direct and coordinate all activities within AOTA headquarters, councils, committees, and affiliate associations relating to the ultimate establishment of standards for continuing certification and registration;

2. Appointment of a coordinating committee, composed of representatives of the AOTA councils, the Delegate Assembly, the affiliate presidents, and such other consultants in special areas as may be needed to assist the AOTA staff member to plan and coordinate all activities, and to see that the membership of AOTA is involved in all phases of the development and implementation of standards;

3. Delegation to the Council on Practice of the responsibility of defining quality practice at various levels and in various specialty areas; the kinds of knowledge and skills needed to practice in each of these areas; and the relationship among the various areas;

4. Delegation to the affiliate association and to the Delegate Assembly of the responsibility for developing and including in their bylaws enforceable ethics clauses;

5. Delegation to the affiliate associations and the representatives of the Council on Practice of the responsibility for determining the kinds of continuing education needs their members have, finding resources in their regions to meet those needs, delineating those needs which cannot be met locally or regionally, and developing models and methods by which the quality of occupational therapy services within the state or region can be evaluated, as well as the means by which members serve as peer reviewers, consultants, and supervisors to improve the kind and quality of occupational therapy services. Affiliate associations and the Council on Practice should also begin to consider how to educate consumers, employers, and therapists about quality service, the legal implications of providing poor quality service with non-qualified personnel, and the importance of hiring qualified occupational therapy personnel.

PHASE II: (analysis of data collected by groups during Phase I, development of plans for continuing education, seeking financial resources for educational programs, estimating costs involved in implementing a set of standards and the necessary supportive services, and preparing standards for continuing certification and registration by the Council on Standards (based on the definition of quality practice prepared by Council on Practice), and the preparation of a plan for implementing such standards.)

PHASE II (Continued)

Other activities to be undertaken during this second phase include educating members of affiliate associations and Council on Practice representatives in how to plan, finance, conduct and evaluate continuing education programs; to work with universities and extension programs to provide necessary kinds and varieties of opportunities for therapists who cannot participate in organized workshops; to develop self-evaluation tests and other educational resource materials to further broaden the kinds of educational materials; to work with employers through the national and affiliate associations to promote concepts of standards for service, accreditation of programs, and continuing certification and registration; to continue educating therapists about their need to participate in continuing education; and to promote consumer and employer education. Finally, a comprehensive plan, including standards for continuing certification and registration and methods of implementation and describing needed supportive services, should be submitted to the Delegate Assembly with an accompanying budget.

Finally, there should be delegated to the appropriate committees and councils (particularly the Recognitions Committee and the Council on Development) the responsibility to establish such Boards and Academies (or their equivalents). The purpose of these should be to encourage and reward members for their achievements and contributions to the profession and to promote the development, organization, and dissemination of knowledge as it relates to specialty areas. Such bodies should have a mechanism for recognizing the contribution of any occupational therapy personnel, regardless of whether he is registered or certified.

PHASE III: Implementation of the standards for continuing certification and registration. Supportive services (such as educational resources) should be available and accessible. Such a program should be nationwide in scope to prevent unnecessary restrictions on mobility, to reduce the need for licensure, and to promote advancement and entry opportunities for occupational therapy personnel.

It is imperative that as many members of AOTA as possible be intimately involved in all stages of development of this program. This plan provides a mechanism whereby national leadership and coordination can be provided while making possible active participation by the members of AOTA in defining the processes, as well as the standards, which are most conducive to maintenance of high quality services in occupational therapy.

Annual reports on the progress being made toward development of standards and supportive services should be made annually to the Delegate Assembly by the AOTA staff member responsible for directing this project and by the various Council chairmen, in addition to quarterly reports to the Executive Board. Proposals for budgets should be submitted with each report. A final report should be presented within three years, if possible, but no later than five years from this date.

Finally, where possible and feasible, grant support to expand the operations of the basic groups assigned to complete this project should be sought, although it is anticipated that the basic cost should be assumed by AOTA.

ACTION BY THE DELEGATE ASSEMBLY:

Adopted as amended.

Date: April 30, 1971

BACKGROUND INFORMATION - RESOLUTION #300-71

I. The Delegate Assembly, on October 30, 1965, "moved and passed unanimously [illegible] resolution to authorize the Council on Standards to establish realistic standards for an effective means of maintaining eligibility for annual renewal of registration and membership, and that the Bylaws be amended to incorporate such standards as criteria for continuing membership in the association".

Lyla Spelbring, OTR, Chairman of the Committee on Standards for the Profession, duly appointed Rosalia Kiss as Chairman of a Sub-Committee on Continuing Registration and Certification to fulfill this charge. Committee members were Dorothy Elliott, OTR, Sigrid Hansen, OTR, Harriet Schmid, OTR, Doris Slack, OTR, Lyla Spelbring, OTR and Mrs. Mary Willy; Mrs. Martha Moersch, OTR, Chairman of the Committee on Continuing Education served as member ex-officio. Resolution #155 was subsequently submitted to the Delegate Assembly at its annual meeting on September 16, 1967. Resolution #155 contained a proposal whereby minimum requirements for registration were to be completed every three years. The responsibility for submitting proof of fulfillment of the requirements remained with the individual AOTA member. The individual members were then responsible for submitting the necessary forms to AOTA headquarters, where the information was to be recorded. A Committee on Continuing Registration and Certification was to be established to consider problems and provide interpretations of policy. The Committee on Continuing Education also was to be responsible for identifying and providing appropriate courses and workshops. This resolution was defeated, and the charge was again returned to the Council on Standards, Committee on Standards for the Profession.

II. At the annual Delegate Assembly meeting of the American Occupational Therapy Association on May 1, 1970, Resolution #286-70 was adopted. This resolution reads:

"Be it resolved, that the Delegate Assembly instruct the Council on Standards to establish realistic standards and methods of implementation for an effective measure of maintaining eligibility for annual renewal of registration and/or certification, and

Be it further resolved, that the supporting material in Resolution #155 be considered in their deliberations and that the Council on Standards report their plan to the Delegate Assembly at the meeting in 1971".

In May 1970, an Ad Hoc Committee on Continuing Certification and Registration was formed to respond to the Delegate Assembly's charge. Membership on this Ad Hoc Committee included:

Miss Jerry A. Johnson, OTR, Chairman, Ad Hoc Committee
Miss Joanne C. MacDonald, OTR, Incoming Chairman, Council on Standards
Mrs. Gail Fidler, OTR, Chairman, Committee on Standards for the Profession
Mr. Fred Odhner, OTR, Committee on Standards for the Profession
Mrs. Charlotte Nesseth, COTA, Committee on Standards for the Profession
Mrs. Irma Bolton, COTA, liaison, Council on Development, COTA Committee
Mrs. Joane Wyrick, OTR, Chairman, Council on Practice
Miss Carlotta Welles, OTR
Mrs. Ruth Brunyate Wiemer, OTR
Miss Margaret Smith, OTR

Members of this Ad Hoc Committee surveyed and prepared reports as background material for the work of the committee.

1. Nineteen professional associations were contacted to determine what, if any, action they had taken to develop standards or models to insure continuing competency among their members. Of these, two, the American Academy of General Practice and the American Dietetic Association, have standards for continuing registration. Partici-

pation in both programs is voluntary, and neither association has imposed standards which invalidate the initial qualifications which permit a member to practice.

It was reported that a third association, the American Osteopathic Surgeons, is using the Professional Examination Service to help them devise a voluntary self-assessment examination, complete with study references, as their preliminary step toward setting standards for continuing registration. (The estimated cost for developing this one evaluation tool ranges from $15,000-$25,000, which is a cash outlay; fees--approximately $25.00 per person--for taking the examination are used to maintain ongoing expenses of the examination.) The American Psychiatric Association has a similar plan for self-evaluation. Other associations are studying the possibility of adopting standards for continuing certification and registration.

2. A review of legal aspects related to standards for continuing certification and registration revealed that it will be very difficult to remove certification or registration from anyone who has fulfilled the basic requirements for becoming a practitioner. This can be done through due process, resulting from a breach of moral or ethical codes. However, every state has laws which require employers who are certified by the state to exercise due care and selection in hiring procedures. Therefore, it is possible for each employing institution to impose or enforce standards relating to continuation of education and the maintenance of qualifications which enable one to provide adequate quality care and treatment. Thus, the employing institution could be held accountable for employees who do not maintain adequate standards of proficiency. This suggests that each employer has a responsibility to evaluate employees and to suggest and support ways in which they can improve their performance. Legally, any standards which are adopted must have well-defined levels of appeal, with the highest appeal being a court of law.

3. Social issues involved in considering the imposition of standards for continuing certification and registration include:

a. the fact that there now exists a serious shortage of qualified health personnel, and all health professions are considering alternative ways (in addition to our traditional educational-diploma route) of qualifying personnel to enter the job market and to progress within the profession;

b. the economic consideration that quality care and the availability of adequate numbers of personnel to provide that care are related so that it is difficult for one to exist without the other;

c. Congress has directed Health, Education, and Welfare to conduct a study of licensure to see if licensing creates artificial barriers which prevent skilled persons from entering or advancing within the health professions;

d. the development of additional standards can be potentially viewed as being discriminatory and as protecting the profession, rather than the consumer, if adequate precautions (such as providing supporting services to enable members of the profession to fulfill the requirements) are not taken; and

e. AOTA should ally itself with other accrediting agencies and bodies so that as institutions are accredited, the service programs in occupational therapy are also accredited. Such an alliance should encourage the use of the already adopted "Standards for Service Programs in Occupational Therapy."

4. The primary focus of unions, civil service legislation, and licensure laws is to establish entry requirements and to maintain jobs, rather than to encourage upgrading and greater competency, except insofar as increased standards are imposed for higher level positions or increases in salary.

5. Ethics clauses adopted by many professions are more descriptive of the jobs to be performed by the members of those professions than they are definitive about the ethical or moral standards to be maintained by professional members. The more general the ethics clause, the more difficult it is to enforce or uphold.

6. Finally, the majority of professionals and occupational groups which were contacted require completion of basic educational requirements, successful completion of an examination, and payment of annual dues or registration fees as the basic requirements to practice. (Interestingly enough, members of AOTA frequently receive more services for the amount of dues--and pay about the same, or less--than many of the other groups surveyed. A majority of other groups require individual subscriptions to professional journals and literature, on top of the basic payment of dues and fees.)

It is also well to note that there is a strong movement in the United States at this period of time to protect consumers, and a number of bills to do this are now under consideration in both federal and state legislatures.

In addition to the studies undertaken by members of the Ad Hoc Committee, a request was sent to the Council on Practice regional coordinators and local chairmen of affiliate associations (with copies to affiliate presidents and Delegate Assembly members) asking that local committees be formulated to consider the charge of the Delegate Assembly, the implications of maintaining a system of continued certification and registration, and to prepare and submit proposals to the Ad Hoc Committee.

These local committees were encouraged to include representatives of both COTAs and OTRs since the matter under consideration has implications for all members of AOTA.

Subsequently, reports and/or proposals were received from all regions of the Council on Practice, from some affiliate associations, and from some individuals. This was an issue which generated a considerable amount of interest (and anxiety) among the membership, and several affiliate associations and regional groups volunteered to undertake further work and planning if requested to do so. Many concerns and issues were raised by the membership, and some of those which were repeatedly mentioned are listed below:

1. There was some confusion about the basic task as the term "re-certification and re-registration" was interpreted by some as referring to renewal of certification or registrztion after this has lapsed; others interpreted the term to mean continuing certification and registration. Proposals and reports which were submitted thus related to the interpretation of the members.

2. There was concern about whether this was an honest attempt to motivate and reward occupational therapists to be more concerned about and to take action to insure that their qualifications to practice prompted high quality care or whether it was an attempt to be punitive for persons who did not maintain their qualifications. There was also fear expressed that some people would lose their right to practice.

3. Many reports suggested that we need a clear definition of what constitutes good practice, as this would form the criteria against which we would evaluate whether or not a person meets certain standards.

4. There was concern about the availability of educational opportunities, as well as the availability of a variety of educational experiences, for therapists in rural areas who work in one-man departments, who have family responsibilities and cannot travel easily, or who have varying needs determined by their area of specialization or level of functioning.

5. All affiliate associations will need to have strong, enforceable ethics clauses.

6. The role and responsibilities to be assumed by AOTA(through its national headquarters and Councils), affiliate associations, individual occupational therapists, and employers of occupational therapists, needs to be clarified if standards are to be established.

7. Many reports and proposals mentioned the necessity to include procedures for appeals, conditions under which exemptions might be granted, and the methods by which one can negotiate for a waiver in any set of standards.

8. Considerable attention was given to the problem of establishing standards according to level (i.e., staff O.T., Supervisor), area (clinical practice, education, research), or specialty (i.e., physical disabilities, psychiatry) and how these aspects of occupational therapy are related to each other.

9. The entry of the professional association into maintenance of standards for persons who have fulfilled the requirements to practice is new, and a number of members questioned the legitimacy of this, stating that this was the individual responsibility of the therapist. What legal, moral, or ethical responsibility does a professional association have to assume this function?

10. Some reports expressed concern about the role of peer review and collaboration, how it should be instituted, and conducted, and whether or not it would be acceptable and useful.

In addition to the concerns which were just discussed, there did appear to be considerable support among the members for AOTA to promote the concept of providing quality care. The provision of such care rests on the premise that each practitioner must continue to educate himself, in a variety of ways appropriate to his needs, after entering professional practice, regardless of the level at which he enters. The need to be continually involved in self-education as it relates to one's practice becomes more necessary for many reasons. Knowledge is developing at a rapid rate. New theories, techniques, and methods of practice in occupational therapy as well as in other professions which affect our own practice, are continually evolving and replacing outmoded or irrelevant theories. Finally, occupational therapists are developing a new sense of professionalism as they move into practice models where supervision is not provided by another profession but must come from members of our own profession.

Given the fact that there is need for continuing education to improve the quality of performance and practice, the central purpose of any set of standards which is adopted should be to provide support through a system of continuing education directed toward the practicing therapists, employers, and consumers. It thus becomes a responsibility of the profession to determine what standards should be established, to insure that there are opportunities available for all members to fulfill the standards, to establish the mechanism for enforcement of the standards, to insure that the standards are not discriminatory and unduly restrictive, to encourage and promote the development of enforceable ethics clauses in the Bylaws of all affiliate associations, and to educate students, therapists, employers and consumers about the elements of quality care and service in occupational therapy. It was with this philosophy that Resolution #300-71 was proposed.

III. Following its adoption, the Executive Board appointed Dr. Jerry A. Johnson as Acting Project Director until such time as a full-time Project Director could be employed. This action was taken in order to develop the basic plans for the implementation of Resolution #300-71, to design the job description for the Project Director, to recommend candidates for the position, and to initiate such activities as seemed basic to the conduct of the project.

An Interim Planning Committee was formed, consisting of: Bernadine Choren, OTR; Joanne MacDonald, OTR; Janice Matsutsuyu, OTR; Cordelia Myers, OTR; Janet Stone, OTR; and Harriet Warren, OTR. Members of the Interim Planning Committee held three meetings: one in July 1971, the second in October 1971, and the third in February 1972. The activities of this Interim Planning Committee were intended to be considered as guidelines for an incoming Project Director who would have the liberty to utilize these plans in toto or to make appropriate changes consistent with the needs of the project and are described in their March 1972 summary report. Mrs. Patricia Mayer Shanahan, OTR was employed as full-time Project Director on February 28, 1972.

DESCRIPTION OF THE

CONTINUING CERTIFICATION PROJECT:

A PROJECT TO MAINTAIN THE COMPETENCY OF OCCUPATIONAL THERAPY PERSONNEL

FROM:

The American Occupational Therapy Association, Inc.
Program Development Staff

May 1973

I. INTRODUCTION

In the vanguard of professional associations to recognize that criteria must be developed to provide measurable evidence of maintenance of professional competency, the American Occupational Therapy Association (AOTA) in 1967 began to explore processes for continuing certification. The significant investment of financial and personnel resources resulted in a mandate by the Association's Delegate Assembly in April 1971 to develop a formal proposal to seek additional funding. Increasing public awareness of the need to establish standards for quality health care has caused the Association to expand and accelerate its efforts, but it should not obscure the fact that the initiative to evolve self-imposed competence criteria was taken by the AOTA itself at a time when it was a decidedly innovative and experimental action.

The Continuing Certification Project will result in methods to support and enable the growth of the profession of occupational therapy as it meets the health needs of today's consumers.

II PROBLEM

The AOTA currently provides mechanisms whereby individuals who successfully complete the requirements for certification are recognized as being competent and capable of providing certain occupational therapy services at the time of entry into the profession. There is no licensing of any level of practice. Certification as "Occupational Therapist Registered" or "Certified Occupational Therapy Assistant" by the AOTA has been accepted as the evidence of professional qualification by the Federal Government, by many state and local civil service systems, and by most employers of health care personnel.

As with many other professions, however, once certified, the occupational therapist's continuing competency to practice is not challenged unless he commits "an immoral or unethical act." Thus initial certification has been a virtual lifetime guarantee of the right to practice.

Members of the AOTA translated their concern that this approach was inadequate into action as long ago as 1967, thus preceding today's vocal demands for consumer protection by insurance companies, legislators, and the consumers themselves. In that year, a plan requiring each member to accumulate within a stated period a given number of points in continuing education was submitted to and rejected by the Association's Delegate Assembly. Concluding that traditional continuing education programs relied too heavily on scores and grades measuring knowledge instead of competency of practice, the AOTA began its search for an alternative approach to continuing certification.

Activities undertaken by the AOTA regional and affiliate associations, committees, and individual members have included:

- a review of the action taken by other professional associations regarding continuing certification;
- a study of the issues involved in continuing certification;
- the approval by the Delegate Assembly of the present plan to develop a procedure for continuing certification (Resolution #300); and
- the funding initially of a part-time project director and subsequently a full-time director, including travel, per diem, and operating expenses.

III PURPOSES

The purpose of the Continuing Certification Project is to insure that occupational therapists deliver consumer services uniformly and continuously consistent with high professional standards.

IV CRITERIA

In the course of systematically involving all levels of the AOTA membership in the evolution of this project, certain criteria have emerged as being crucial to its ultimate acceptance:

- An assessment procedure should serve as a learning experience for each therapist while evaluating his individual competence.
- The evaluative method should promote desirable changes in the techniques of practice through feedback to the profession as a whole.
- There are several functional levels (i.e., aides, certified occupational therapy assistants, and occupational therapists registered) and specializations (such as educators, administrators, or specialized practitioners in fields such as psychiatry, physical disabilities and mental retardation) within occupational therapy which evaluation mechanisms must take into consideration.
- The profession should not impose more specific standards without also making available learning experiences which will enable the practitioner to upgrade his level of competency.
- A continuing certification procedure should promote upward mobility within the profession and continually serve to improve the quality of care at all levels of practice.
- A continuing certification procedure must enable the profession to define the levels at which practitioners should practice and also inform the consumer of what he can expect from the service.

V OPERATIONAL PROCEDURES

A. Duration

The term required to complete this project is estimated at two years from date of inception as follows:

- Objective 1 - Nine months to commence at outset
- Objective 2 - Twelve months to commence the third month
- Objective 3 - Thirteen months to commence the tenth month upon completion of Objective 1
- Objective 4 - Twelve months to commence the thirteenth month

B. Objectives and Methodology

Objective 1: Development of Standards

a. definition of appropriate objectives, scope and process of occupational therapy practice.

b. delineation of appropriate roles and functions of various levels and specialties of therapists.

c. identification of necessary knowledge and skills applied in occupational therapy.

d. identification of specific knowledge and skills needed by professional categories.

e. membership input and consensus.

METHODS - Project staff will draw upon key AOTA resource members, committees, councils, specialty subpanels, local task groups, and expert consultants. An extensive review of professional literature was begun in January 1972, and supplemental information will be derived from the AOTA - National Institutes of Health contract to delineate the roles and functions of occupational therapy personnel. Professional and technical occupational therapy curricula will be examined. Affiliate association and member input will be sought by special mailings, meetings, visitations, and supplementation of local budgets to achieve this and subsequent objectives.

Objective 2: Development of Educational Opportunities

a. identification of type and content of learning experiences necessary for therapists to acquire and maintain essential knowledge and skills.

b. identification of available and potential educational and financial resources.

c. development and implementation of accessible immediate and continuing education programs.

METHODS - Project staff will conduct a literature review and will utilize the continuing education experience of the AOTA's affiliate association education committees, as well as expert consultants in continuing education. Such ongoing potential resources as regional medical programs, university extension divisions and state health programs will be studied.

Objective 3: Development and Implementation of a Continuing Certification Process

a. identification of assessment techniques and procedure.

b. membership involvement in pilot testing of selected techniques and procedures.

c. final selection in terms of suitability, feasibility and accuracy.

d. implementation

METHODS - Project staff will conduct a review of current literature on possible continuing certification techniques, such as examinations, peer review, and self-assessment. Members, local task groups and consultant experts in education, psychology, data processing, and testing will be utilized. Once selection of the appropriate assessment technique and procedure is made by project staff in conjunction with membership, the continuing certification process will be implemented.

Objective 4: Education of Employers and Consumers

a. identification of appropriate employers and consumer groups.

b. formulation of educational methods and content.

c. implementation.

METHODS - Project staff will work with affiliate associations, AOTA councils and committees, and consultants to develop and implement a system to educate consumers and employers, about standards of service, the continuing certification process, and the importance of utilizing competent occupational therapists.

APPENDIX 11

Project Time-Table

AOTA CONTINUING COMPETENCY PROJECT:
to develop a methodology for establishing standards of job performance and educational opportunities to ensure continuing competency for health care practitioners

CONTRACT TIME TABLE

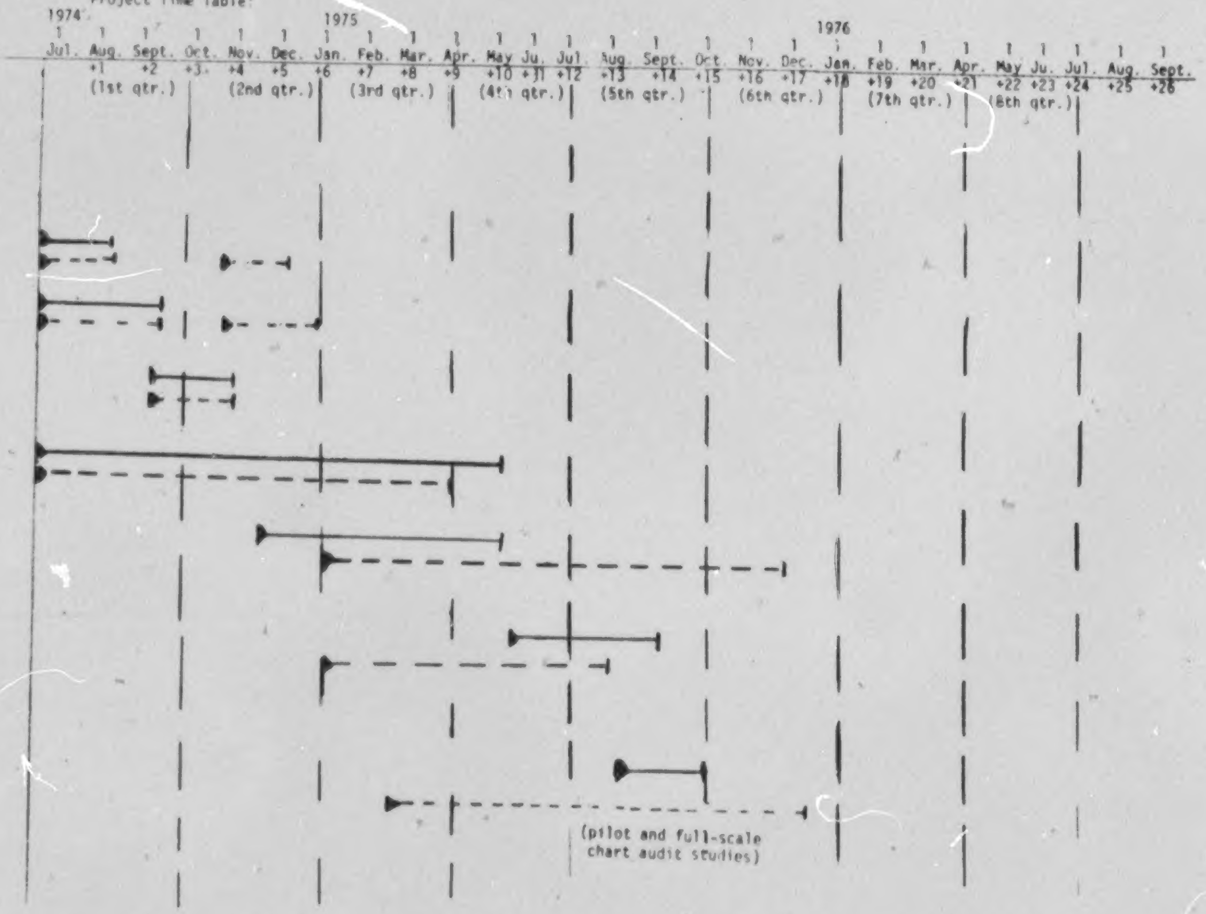
CONTRACT NO. NO1-AH-4116

July 1, 1974 to Aug. 31, 1976

Key:
Projected time ________
Actual time ----------

Project Time Table:

Projected Activities (keyed to contract scope of work)	Proposed Time: Start	Finish
Part I:		
1. develop a methodology for establishing standards of job performance for health care practitioners--by using the following procedures which shall be continuously assessed to determine feasibility as a generic model:		
a. selection of 5 areas of specialty occupational therapy practice	Immed.	+1 mo.
b. selection of practitioners and educators as consultants and/or task force members	Immed.	+2 mo.
c. selection of special consultants with expertise in performance evaluation and the development of standards of performance	+2 mo.	+4 mo.
d. delineation of roles and functions in the 5 areas of specialty practice	Immed.	+10 mo.
e. review and critique of the delineation of roles and functions. Revisions made as needed	+4 mo.	+10 mo.
f. formulation of a procedure for developing measurable standards of performance and the preparation of preliminary standards of performance for each of the specialty areas	+ 10mo.	+14 mo
g. review and critique of the standards by selected consultants and members of the Councils on Practice and Education. Revisions made as needed. Part I completed	+13mo.	+15 mo.



AOTA CONTINUING COMPETENCY PROJECT:
to develop a methodology for establishing standards of job performance and educational opportunities to ensure continuing competency for health care practitioners

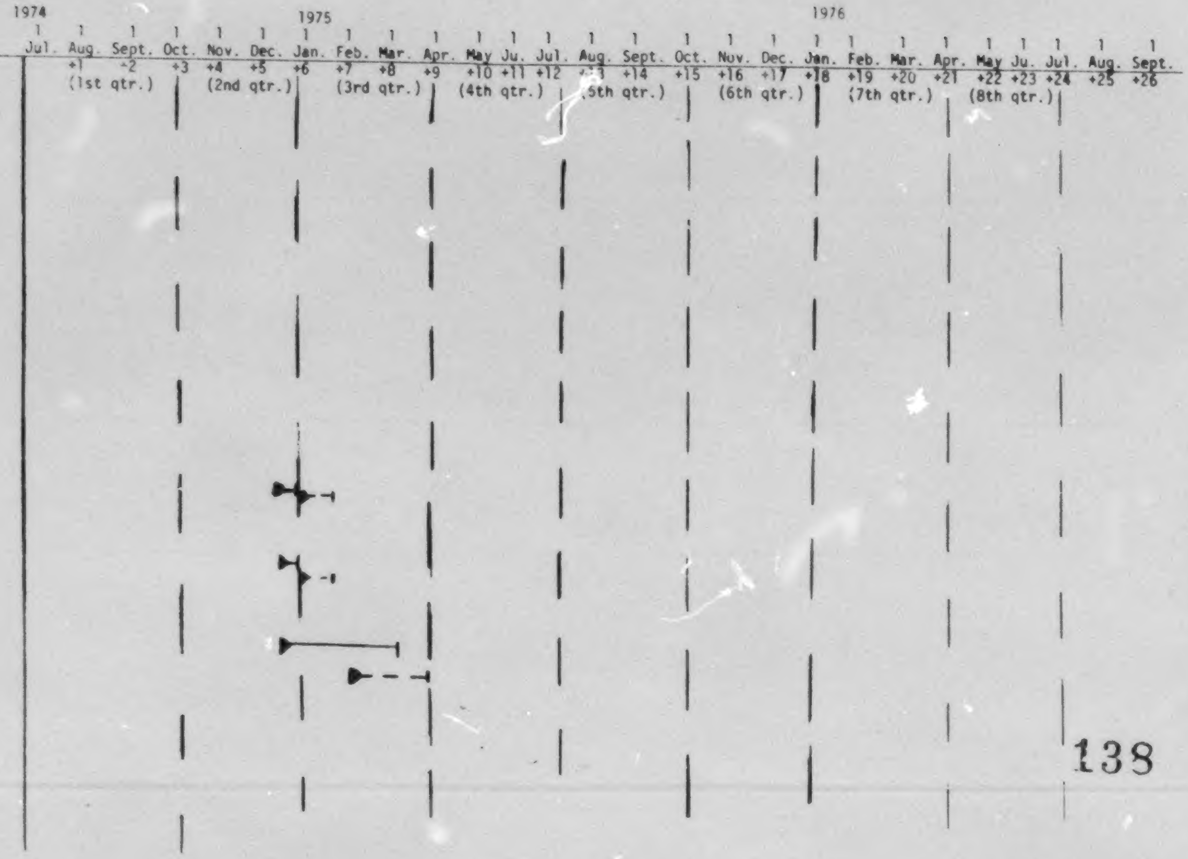
CONTRACT TIME TABLE

CONTRACT NO. NO1-AH-4116

July 1, 1974 to Aug. 31, 1976

Key:
Projected time ________
Actual time------------

Projected Activities: (keyed to contract scope of work)	Proposed Time: Start	Finish
Part I.:		
2. develop a methodology for establishing continuing education opportunities which assist health care practitioners and educators to maintain and increase job competency. This shall be accomplished through studies conducted at the regional and national levels. Evolving procedures shall be continuously assessed and revisions made where necessary to enhance the generic application of the model.		
a. regional level study: the focus is to develop continuing education programs at the local level. The project staff will work with affiliate association members to assess learning needs and develop and implement their own continuing education programs.		
(1) selection of a regional area, containing several affiliate associations	+5 mo.	+6 mo.
(2) selection of 1 of the 5 specialty areas of occupational therapy practice used in Part I	+5 mo.	+6 mo.
(3) selection and orientation of regional consultants and task forces of expert practitioners and educators in the specialty areas	+5 mo.	+6 mo.

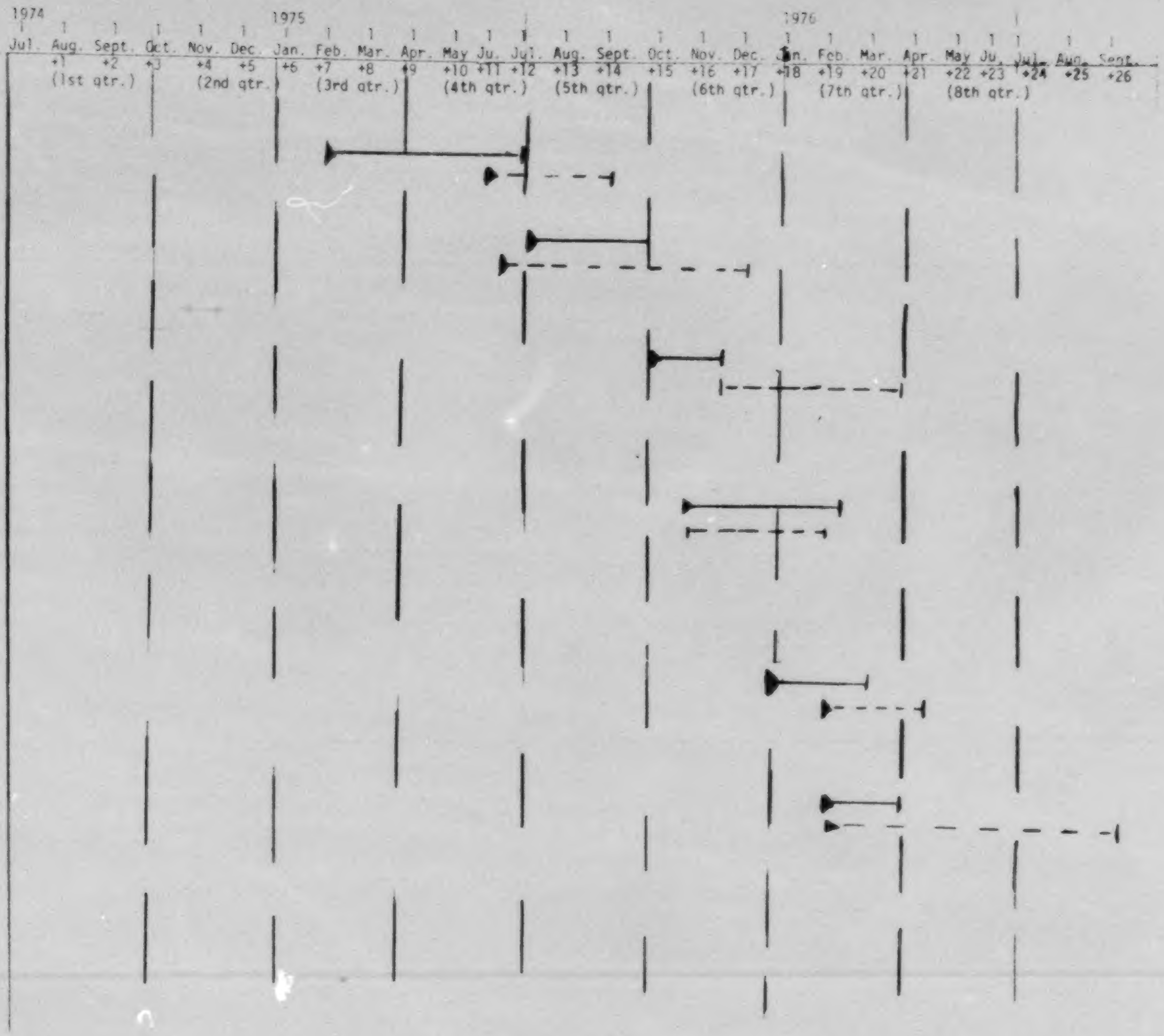


Projected Activites:

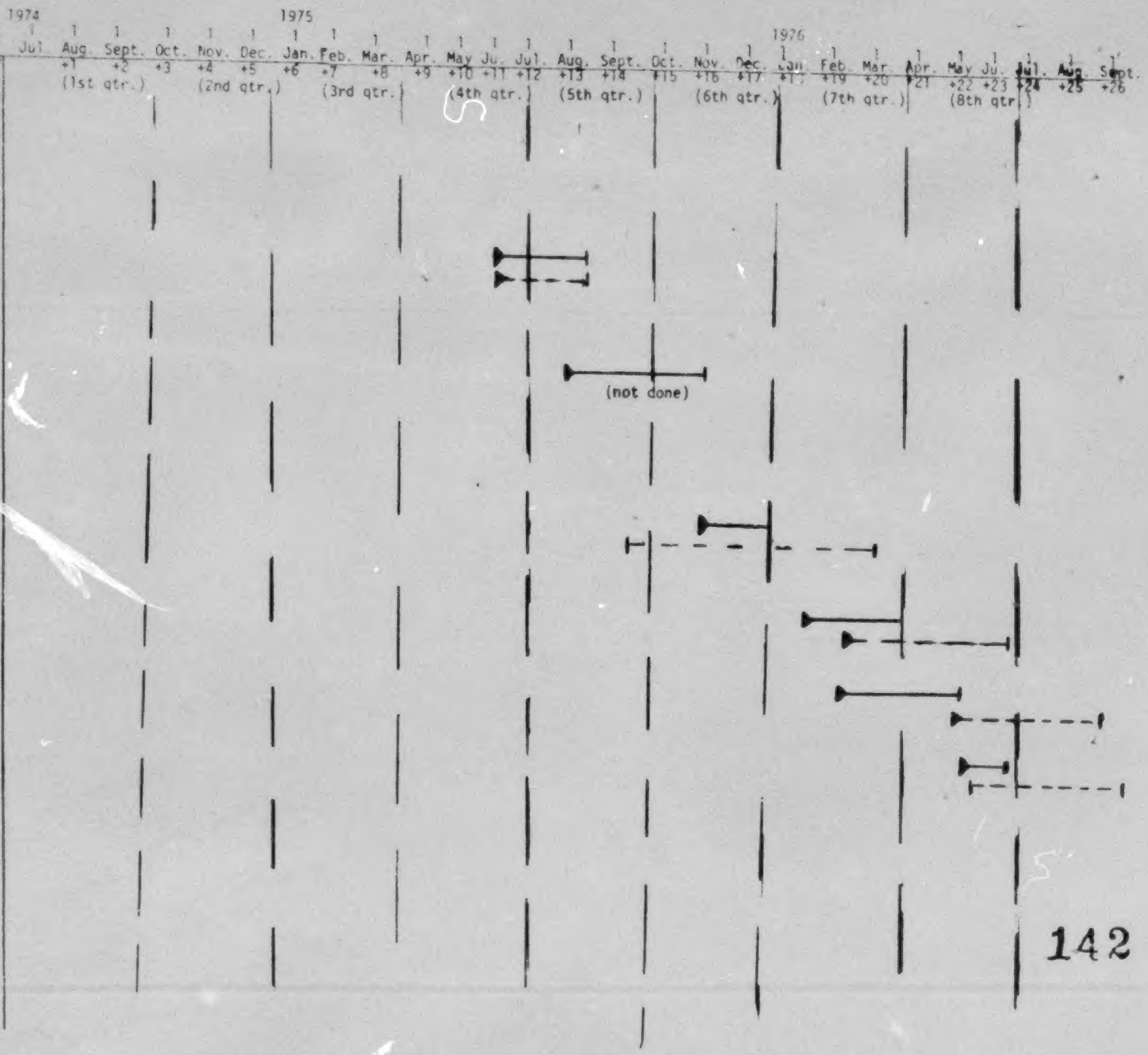
Part II (continued)

(4) project staff, consultants, and regional task force members shall:

	Proposed Time:	
	Start	Finish
identify the knowledges and skills required to perform the specialty roles and functions	+8 mo.	+12 mo.
develop self-assessment instruments which practitioners and educators can use to assess their knowledge and skills in the specialty area	+12 mo.	+15 mo.
utilize the self-assessment instrument as a survey instrument to identify what continuing education programs are needed within the regional area	+15 mo.	+17 mo.
analyze survey data and conduct a regional survey to identify available regional continuing education programs in the specialty area; and identify additional programs and resources which are needed but not available	+16 mo.	+19 mo.
analyze the survey data and plan how to develop, obtain, and publicize the continuing education programs needed in the specialty area	+18 mo.	+20 mo.
implement the continuing education plan	+19 mo.	+21 mo.



Projected Activities: Part II (continued)	Proposed Time: Start	 Finish
b. national level study the focus of the national level study is on the development of a variety of self-study materials which can be made available to rural as well as urban practitioners and educators		
(1) selection and orientation of consultants and task force of practitioners and educators in the specialty area chosen in 2.a.(2)	+11 mo.	+13 mo.
(2) identification of continuing education needs in the specialty area by means of a sample survey utilizing the self assessment instrument developed in the regional study	+13 mo.	+16 mo.
(3) identification of the kinds of self-study materials needed (based upon the survey data)	+16 mo.	+18 mo.
(4) development of indicated self-study guides and materials	+18 mo.	+21 mo.
(5) evaluation of the self-study materials by a sample group of practitioners and educators	+20 mo.	+22 mo.
(6) distribution of the self-study material to practitioners and educators.		



APPENDIX III

AOTA Data Questionnaire (1973)

The American Occupational Therapy Association, Inc.

6000 Executive Boulevard, Rockville, Maryland 20852

for AOTA use

PLEASE KEEP IN MIND . . .

1. Read carefully the *italicized* instructions accompanying individual questions.
2. PRINT all responses, and mark appropriate boxes with an "X".
3. If you wish to change a response and you cannot erase, draw a line through the entire response, not just the answer box.
4. In several questions, you are asked to choose a response from a rather long list. In each case, be sure to read the entire list before making your selection.
5. Do not remove the attached label. It identifies your questionnaire.
6. Please return completed questionnaire in the enclosed envelope.

(please correct any error in name and address)

Section A – NAME and ADDRESS

1. In what COUNTY (Note: that's county, NOT country) is your address located?

2. If you wish your maiden name (or other previous last name) listed in the 1974 Directory, please print that name here.

Section B – PERSONAL INFORMATION

3. Year of Birth *(last 2 digits only–ex: 1945=45)*

4. Ethnic Origin *(check one)*:

1 ☐ American Indian
2 ☐ Asian
3 ☐ Black
4 ☐ Mexican American
5 ☐ Puerto Rican
6 ☐ White
7 ☐ Other ________ *(specify)*

5. Sex:

1 ☐ Female   2 ☐ Male

6. Marital Status:

1 ☐ Married
2 ☐ Divorced or Separated
3 ☐ Widowed
4 ☐ Single

7. Do you presently have any dependents?

1 ☐ No   2 ☐ Yes ________ *(number)*

1973 Data Questionnaire

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Section C – PROFESSIONAL or TECHNICAL EDUCATION

This section deals only with your education in occupational therapy. Education in fields other than OT is covered in Section D.

8. Do you have a baccalaureate degree with a major in occupational therapy?

1 ☐ No   2 ☐ Yes

9. If YES:

School

Year Earned *(last 2 digits)*

10. Do you have a master's degree in occupational therapy?

1 ☐ No   2 ☐ Yes

11. If YES:

School

Year Earned *(last 2 digits)*

12. If not already listed above, at what institution did you receive your basic education in occupational therapy?

School

1 ☐ Certificate or Diploma   2 ☐ AA Degree

Year Earned *(last 2 digits)*

13. Are you now pursuing an academic degree?

1 ☐ No   2 ☐ Yes

14. If you are now an OTR, were you previously a COTA?

1 ☐ No
2 ☐ Yes

15. If you are now a COTA, how did you reach your certification? *(check one)*

1 ☐ AOTA approved educational program—Comprehensive
2 ☐ AOTA approved educational program—General Practice (Geriatrics)
3 ☐ AOTA approved educational program—Psychiatry
4 ☐ Grandfather Clause—General Practice (Geriatrics)
5 ☐ Grandfather Clause—Psychiatry
6 ☐ Military Tech. Resolution #284-70

Section D — OTHER EDUCATION

16. What is your highest degree in a field other than occupational therapy? *(check one)*

1 ☐ Associate
2 ☐ Baccalaureate
3 ☐ Masters
4 ☐ Doctorate
5 ☐ Other ______ *(specify)*
6 ☐ None

Year Earned *(last 2 digits)* ______

Major field of study ______

School ______ *(name and location)*

______

17. Are you licensed or certified in any of the following fields? *(check up to 2)*

01 ☐ Education
02 ☐ Nursing
03 ☐ Physical Therapy
04 ☐ Psychology
05 ☐ Social Work
06 ☐ Special Education
07 ☐ Speech Pathology/Audiology
08 ☐ Therapeutic Recreation
09 ☐ Vocational Rehabilitation
10 ☐ Other ______ *(specify)*
11 ☐ None

Section E — EMPLOYMENT

18. What is your present employment status? *(check one)*

1 ☐ Employed full-time (30 or more hrs. per week)
2 ☐ Employed part-time (less than 30 hrs. per week)
3 ☐ Working as volunteer
4 ☐ Not employed—plan to work again
5 ☐ Not employed—don't plan to work again

(If you checked box 1, 2 or 3, continue with the next question. If you checked box 4 or 5, skip to question 28.)

If you are self-employed (that is, if you receive payment directly from your patient/client or his agent, or if you are paid on a contractual basis), check here . . . . . 1 ☐.

19. Present Employer — *PRINT the name of your present employer as you wish it to appear in the 1974 Directory. If you work at more than one facility, list the PRIMARY one.*

EMPLOYER NAME

ADDRESS *(number)* *(street)*

CITY STATE ZIP CODE

20. Describe the PRIMARY facility in which you wor
(check one in Category A and one in Category B)

Category A — CONTROL or OWNERSHIP

1 ☐ Federal, Vet. Admin.
2 ☐ Federal, other civilian
3 ☐ Federal, military
4 ☐ State
5 ☐ City/County
6 ☐ Private, profit
7 ☐ Private, nonprofit

Category B — SETTING *(READ ENTIRE LIST, th check the one that best describes your facility)*

01 ☐ College, 2 year
02 ☐ College/University, 4 year
03 ☐ Community Health Program
04 ☐ Community Mental Health Center
05 ☐ Correctional Institution
06 ☐ Day Care Center
07 ☐ Health Maintenance Organization
08 ☐ Home Health Agency

Hospital, Short Term (less than 30 days)
09 ☐ General
10 ☐ Pediatric
11 ☐ Psychiatric
12 ☐ Other specialty

Hospital, Long Term (30 or more days)
13 ☐ General
14 ☐ Pediatric
15 ☐ Psychiatric
16 ☐ Other specialty

17 ☐ Private Practice
18 ☐ Public Health Agency
19 ☐ Regional Medical Program
20 ☐ Rehabilitation Center
21 ☐ Research Facility
22 ☐ School System (including private school)
23 ☐ Sheltered Workshop
24 ☐ Skilled Nursing or Intermediate Care Facility
25 ☐ Other ______ *(specify)*

21. How long have you worked in this facility? ______ Y

22. Describe any other facility where you presently work. *(Select the appropriate codes from categories A and B above and enter them at right)*

Codes
☐
☐

23. What is your official position title at your primary pla of employment?

______

24. What is your PRIMARY function? *(check one)*
01 ☐ Administration
02 ☐ Consultation
03 ☐ Provide direct patient/client service—Evaluation & Planning
04 ☐ Provide direct patient/client service— Implementation
05 ☐ Provide direct patient/client service— Both **03** & **04** above
06 ☐ Public Relations/Information
07 ☐ Research
08 ☐ Supervision
09 ☐ Classroom Teaching
10 ☐ Field Teaching
11 ☐ Other ______________ *(specify)*

25. If you have a SECONDARY function, select the appropriate code for that function from the list above and enter it at right. Code ☐

26. Are you responsible for developing the budget for the OT department in your facility?
1 ☐ No 2 ☐ Yes

27. IF you are presently involved in the delivery of OT services:

a. What is the age range of the patients/clients with whom you usually work?
1 ☐ 0-2 yrs.
2 ☐ 3-12 yrs.
3 ☐ 13-19 yrs.
4 ☐ Both 2 & 3 above
5 ☐ 20-64 yrs.
6 ☐ 65+ yrs.
7 ☐ Mixed ages

b. What are the health problems of the patients/clients you encounter most frequently in your work? *(Select up to 5 in order of frequency and enter the codes for your selections in the spaces provided)*

01 Alcoholism
02 Amputation
03 Arteriosclerosis
04 Arthritis/Collagen Disorder
05 Behavior Disorder
06 Burns
07 Cancer
08 Cerebral Palsy
09 Character Disorder
10 CVA/Hemiplegia
11 Developmental Disability other than #19
12 Drug Abuse
13 Fracture
14 Hand Injury
15 Hearing Disability
16 Heart Disease
17 High Risk Population
18 Kidney Disorder
19 Mental Retardation
20 Multiple Sclerosis
21 Muscular Dystrophy
22 Neurosis
23 Peripheral Nerve Injury
24 Psychosis
25 Respiratory Disease
26 Spinal Cord Injury
27 Visual Disability
28 Well Population
29 Other ______________ *(specify)*

Codes
☐ ← Most Frequent
☐
☐
☐
☐

28. If you are presently unemployed, how long ago were you last employed? ________ months ________ yrs.

29. Are you fluent in any of the following languages? *(check up to 2)*
01 ☐ American Indian
02 ☐ Arabic
03 ☐ Chinese or Japanese
04 ☐ French
05 ☐ German
06 ☐ Italian
07 ☐ Portuguese
08 ☐ Russian or Slavic languages
09 ☐ Sign language
10 ☐ Spanish
11 ☐ Other ______________ *(specify)*

PROFESSIONAL INCOME

AOTA receives almost daily requests for information about the cost of providing occupational therapy services. To satisfy these requests, and to provide your association with the data necessary to do its job effectively, accurate salary information is needed.

Because one's income is a private matter, this "Income" section can, if you desire, be detached from the main questionnaire and mailed separately. No *individual* identification need be included. For the data to be useful, however, some *general* information is needed.

Cut Here

Cut Here

1. Membership category *(check one)*: 1 ☐ OTR 2 ☐ COTA
2. Please copy the codes for your answers to question 20 here ☐ A ☐
3. Please copy the code for your answer to question 24 here . . . . ☐
4. In what state (or country, if outside U.S.) do you work? ______________
5. Employment status: 1 ☐ Full-time 2 ☐ Part-time
6. Annual professional income:
1 ☐ . . . up to $6,000
2 ☐ $6,000–7,999
3 ☐ $8,000–9,999
4 ☐ $10,000–11,999
5 ☐ $12,000–13,999
6 ☐ $14,000–16,999
7 ☐ $17,000–19,999
8 ☐ $20,000–23,999
9 ☐ $24,000+
7. If you provide consultant services, what is your fee? ________ per hr.
________ per day.

Section F – OTHER PROFESSIONAL EXPERIENCE

30. What do you consider to be your main areas of work experience? *(Select up to 5 from the lists below, and enter the codes for your selections in the spaces provided)*

GENERAL AREAS

01 Administration
02 Communication
03 Comprehensive Health Planning
04 Curriculum Design
05 Fiscal Management (budget)
06 Grant Writing
07 Legislation
08 Personnel Management/Supervision
09 Program Development/Organization
10 Programmed Instruction
11 Public Relations
12 Research Methods
13 Teaching Methods

SPECIFIC AREAS

14 Activity Analysis
15 Adaptive Equipment
16 Architectural Planning and Design
17 Motor Functioning
18 Sensory Integrative Functioning
19 Cognitive Functioning
20 Social Functioning
21 Psychological Functioning
22 Group Process
23 Infant Stimulation
24 Orthotics
25 Prosthetics
26 Self Care Performance
27 Play Performance
28 Work Performance
29 Daily Life Adjustment
30 Other ______________________________
(specify)

Codes
____ ← **Most Experience**
____
____
____
____

31. Could you teach or consult in any of the areas in question 30?

1 ☐ No 2 ☐ Yes, in ____, ____, ____, ____
(code) (code) (code) (code)

32. If continuing education opportunities were made available to you, what areas would best fulfill your needs? *(Select up to 4 from the lists in question 30, and enter the codes in the spaces at right)*

Codes
____ ← **Most Needed**
____
____
____

33. Delegate Candidacy – according to AOTA bylaws, candidates for delegate and alternate to the Delegate Assembly must have had a minimum of five years of active practice, one year in an official position in a local association, and one year of experience on a national committee.

a. Have you had at least five years' experience in active practice?

1 ☐ No 2 ☐ Yes

b. Have you served for a year or more in an official capacity (officer, committee member) with an occupational therapy affiliate association?

1 ☐ No 2 ☐ Yes

c. Have you served for a year or more on an AOTA committee?

1 ☐ No 2 ☐ Yes

34. Have you been involved in and/or held office in community or political organizations?

1 ☐ No 2 ☐ Yes

35. Have you ever had a professional paper published in a journal, book or monograph?

1 ☐ No 2 ☐ Yes

The American Occupational Therapy Association, Inc.
6000 Executive Boulevard
Rockville, Maryland 20852

APPENDIX IV

List of Task Force Members and Consultants

Part 1 & 11

Part 1

Task Force Members, Consultants, Coordinating Committee Members

Task Force Members

The task forces developed the preliminary editions of the standards which were subsequently reviewed and evaluated by several hundred therapists. The task force members included:

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Consultants with expertise in developing standards of job performance and patient care evaluation studies provided advice and guidance to the Project Staff and task force members. The consultants included:

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AOTA Continuing Certification Program Coordinating Committee

Under the auspices of the AOTA Continuing Certification Program, and not funded by this contract, the Project Staff worked with the following representatives of AOTA groups which are concerned with the development of the AOTA Continuing Certification Program:

Committee Member:	Representing:
Bertha Bailey, COTA* 10922 Ritow Houston, Texas 77034	COTA Chairperson and Council on Development
Carole Ann Hays, OTR University of Michigan Medical Ctr. 1405 E Ann Street Ann Arbor, Michigan 48104	Executive Board and Delegate Assembly
Gary Kielhofner, OTR UAF Training Coordinator Occupational Therapy Department University of California Neuro-Psychiatric Institute 760 Westwood Plaza Los Angeles, California 90024	Student Organization and Member-at-large

Committee Member:	Representing:
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Lyla Spelbring, OTR** Occupational Therapy Department Eastern Michigan University Ypsilanti, Michigan 48197	Member-at-large
Nancy Talbot, OTR Occupational Therapy Department Sargent College of Allied Health Professions Boston University Boston, Massachusetts	Executive Board; Council on Education and Council on Finance

* new member as of October 1975

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Part 11

Task Force Members and Consultant

Task Force Members

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APPENDIX V

1. The Roles and Functions of the Occupational Therapist:
    - As a Mental Health Practitioner
    - In the Treatment of the Developmentally Disabled Client
    - In the Treatment of the Physically Disabled Client
    - In the Treatment of the Stroke Client
    - In the Treatment of Clients with Arthritis or Rheumatic Disease

2. Glossary of Terms

Prepared under the auspices of the AOTA Continuing Competency Project Contract No. NO1-AH-44116.

January 1976

THE ROLE AND FUNCTIONS OF THE OCCUPATIONAL THERAPIST AS A MENTAL HEALTH PRACTITIONER

BY DIANE SHAPIRO, M.A., OTR
PRINCIPAL INVESTIGATOR

General Definition of Occupational Therapy[1]

Occupational therapy as an applied science is concerned with directing man's participation in selected tasks to restore and enhance performance, to facilitate learning of tasks identified as essential for adaptation and productivity, to minimize pathology and to promote the maintenance of health. Its fundamental objective is the development and maintenance of the capacity throughout the life span, to perform with satisfaction to self and others, those tasks and roles essential to productive living.

Reference to occupation in the title is in the context of man's goal- directed use of time, energy, interest and attention.

The Role and Function of the Occupational Therapist as a Mental Health Practitioner

The specific roles and functions of an occupational therapist as a mental health practitioner with individual or groups of clients are related to: (1) screening-evaluation, (2) treatment or program planning and (3) treatment or program implementation. Secondary or supportive roles and functions may include education and supervision of students or technical staff, administration, research and consultation.

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[1] From Occupational Therapy: Its Definition and Functions, AOTA 1972.

The scope of the role of the occupational therapist which is described in this document is limited to the occupational therapist working with adult clients.

The clients are individuals who have demonstrated difficulty in management of their life tasks because of any number of factors caused by either emotional and/or environmental stress or pathology. Clients of all ages receive the services of the occupational therapist, however, referrals come from other professionals, relatives, or directly from clients. Services are offered in acute or long-term private or public hospitals, psychiatric clinics, schools, community mental health programs, clients' homes or private practice setting.

1. Evaluation

The first phase of occupational therapy intervention is screening and evaluation of task performance, i.e., the performance of self-care, work and play tasks, the activities of daily living. The therapist begins the screening process by making a generalized assumption about whether the client needs some kind of treatment. Observation of client, and/or family interview, and a referral often indicate broad areas of dysfunction. During the screening phase, the therapist, for example, may ask the client to describe his/her normal daily activities. A poor balance of work and play experiences would be indicative of the need for evaluation. In all cases, the screening is focused upon observation of the client performing an activity and/or an interview with client and/or family about the client's ability to perform within his or her occupational and supportive roles. The therapist must decide from this cursory information whether or not the client can participate in a thorough evaluative procedure or if a postponement is necessary. A frequent contraindication for evaluation may be an acute psychotic state. At such times, medication and supportive diversional activities are recommended.[2] The performance of an individual in a highly agitated state may not be indicative of his or her actual ability to perform.

If the client is able to participate in the evaluation, the therapist must select the appropriate procedures. In some facilities, all clients are evaluated with the same procedures. In others, the therapist will select one based upon the client's specific needs and/or presenting symptoms. The evaluation procedure, often designed by the therapist, is an actual activity-oriented test situation. For example, an evaluation battery may include a craft project (with written and/or oral directions), a typing test, a group project (several clients sharing a task) and one or more commercially available tests.

The therapist would assign simulated tasks or actual activities and observe the client's performance in each area. Once the evaluation is completed, and the client's task abilities and limitations have been identified, the therapist would decide upon the causes of limitation in terms of skill deficits. Additional or more finite evaluation in skill areas such as perceptual-sensory integrative skills, cognitive skills, intrapersonal and interactional skills, and physical motor skills, may be indicated. For example, if the client was unable to perform the tasks that were dependent upon perceptual-sensory-integrative skills, standardized tests of perceptual-sensory integrative skills may be administered. All areas of causative factors are explored by further evaluation with possible referral to specialist, i.e., neurologist, opthamologist, or psychologist; visit to home,or interview with family members.

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[2] These instances are likely to occur in inpatient programs, but are less likely encountered in outpatient or community programs.

A report of findings including all abilities, limitations, environmental conditions and assumptions regarding the nature of the cause is prepared for presentation to colleagues, supervisor and client.

11. Treatment or Program Planning

The second stage of intervention, treatment or program planning, consists of organizing a comprehensive method of helping the client to correct deficient skills, acquire new skills and change defined environmental obstacles.

The process of planning must account for the client's aspiring and actual occupational role, developmental stage, socioeconomic status, length of treatment time and motiviation for change.[3]

Priorities for selection of skill integration are chosen collaboratively by the client, therapist and other professionals. The selection may be based upon a developmental sequence (defined, for example, by Piaget or Erikson) or upon an immediate identified need such as the care of a child or personal hygiene.

Environmental factors are also considered in the selection of priorities. A change in the environment, either physical or personal, may incorporate the use of existing abilities. An out-patient, for example, may be distressed because of an inability to cope with a job assignment. A change in job task may maximize a specific ability.

The treatment program planning report includes all recommendations for change (goals), the specific therapeutic techniques to be used, the estimated length of time, the financial implications, the therapist's judgement regarding prognosis, and plans for after or continuing care.

---

[3] Dealing with client's motivation is a difficult issue. Amotivational syndromes are frequently associated with emotional disorders and is possibly a primary factor of unsuccessful treatment in mental health. Occupational therapists usually try to encourage motivation for change by presenting programs that lead to gentle and rather rapid change in areas that are "nonthreatening" to the client. Before any major change can be tolerated, the client must accept the need for and the often painful process of change.

111. Treatment - Program Implementation

The assumptions about how change in human behavior occurs are the basis of the techniques chosen for occupational therapy intervention. Occupational therapists ascribe to various different theoretical principles regarding the manner in which the activity process changes behavior. The implementation of a therapeutic program or specific technique is dependent upon the chosen theoretical perspective.

The following three examples will illustrate three different theoretical approaches and use of techniques.

1. A 45 year-old male accountant, recently unemployed because of his company's bankruptcy, has a second "psychotic depression". He was discharged from an in-patient service, is on medication, and was referred to out-patient occupational therapy by his psychiatrist. Ability to concentrate, attend to a task and sustain performance are his major strengths. His despair, most evidenced by a slovenly appearance, considerable weight loss and lack of motivation are factors most detrimental to his present functioning. Employment is identified by client and wife as an immediate need.

   The therapist in consultation with a dietitian could discuss recommendations for a diet and develop a behavior modification program to reinforce[4] proper eating habits. The wife can assist in the administration of positive reinforcement following self-care and grooming behaviors. As his appearance improves, the therapist can begin role-playing techniques as simulated job interview experiences and then refer the client to a vocational counselor or a placement bureau.

A supportive program to maintain the client's strengths would concurrently be assigned. Those activities or hobbies that interest him as well as require concentration and attention would be offered.

2. A 29 year-old female high school graduate with a long standing history of schizophrenia, repeated hospitalizations, and unemployment, is an inpatient in a state hospital. Her major strengths are compliance and willingness to cooperate. She functions at a very low developmental level and has never been able to successfully complete a task other than simple craft projects. Her posture is poor; she has a shuffling gait, weakened muscle tone, absent eye contact and poor motor coordination. Sensory integrative techniques as described by

---

[4] Specific reinforcers are selected by the client- praise, tokens and coffee-breaks are some examples.

Lorna Jean King, OTR, are prescribed.[5]

Techniques that provide vestibular stimulation, such as rolling and spinning exercises are implemented. These activities can be offered in a group or individually.

3. A 18 year-old male was referred to an out-patient clinic by the school psychologist because of a two-year history of amphetamine abuse, truancy and poor conduct in class. His grades were high in English, average in other subjects and failing in mathematics and physical education. Patient's parents report delayed developmental landmarks and general clumsiness as compared to siblings.

The symptom of drug abuse, in this case may be best handled by the psychiatrist. The occupational therapist would select activities based upon the defined developmental sequence of perceptual sensory integrative skills of A. Jean Ayres[6] and Newell Kephart[7]. Skill in perceptual sensory integrative performance would be likely to help him attend to the structure of school and authority and may lessen his need for antisocial behavior.

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[5] Lorna Jean King, "A Sensory Integrative Approach to Schizophrenia," AJOT. Vol. 28, No. 9, October 1974.

[6] A. Jean Ayres, "The Development of Perceptual-Motor Abilities: A Theoretical Basis for Treatment of Dysfunction", The Development of Sensory Integrative Theory and Practice. Kendall/Hunt Publications, Inc., Dubuque, Iowa, 1974.

[7] Newell Kephart, Slow Learner in the Classroom. Charles C. Merrill, Ohio 1960.

Concurrently, activities that incorporate his verbal skills such as debate groups and acting classes, would be assigned.

The occupational therapist may not be the person responsible for administration of all activities. Often an occupational therapy assistant or recreational therapist helps implement the program. The occupational therapist is usually in charge of planning, selecting and assigning the particular programs or groups.

In many facilities the occupational therapist functions as the coordinator of clients' activities. This requires that the therapist in addition to direct intervention, assign the client (if this is indicated) to a schedule of daily experiences. The client's treatment schedule is coordinated with other disciplines and services and/or the family, if the client is living outside of the treatment facility. The schedule changes during each phase of intervention. During screening-evaluation and planning, the purpose of the total schedule is diagnosis and orientation. Initially during treatment-program intervention, the schedule is focused upon therapeutic activities such as acquisition of skills. Later it is focused upon transition away from the treatment facility. Often activities outside of the facility such as employment, membership in the "Y" and time with the family are assigned so that the client can gradually adjust to the normal demands of independent adult life.

IV. Reevaluation and Termination

Reevaluation of the client and the course of treatment are considered throughout the program. Recommendations for changes are made accordingly.

Ideally, the termination of treatment is recommended upon achievement of goals. Reimbursement policies, facility requirements and client's motivation are often factors that influence the point of termination. These factors are identified early so that plans can consider them.

This document was prepared under the auspices of the AOTA-HEW Continuing Competency Contract #NO1-AH-44116. The document was prepared as a frame of reference for the development of standards of practice for occupational therapy services in a mental health program. The document was prepared solely for the purpose of this contract and is not an officially approved AOTA document at this time.

THE ROLE AND FUNCTIONS OF THE OCCUPATIONAL THERAPIST IN THE TREATMENT OF THE DEVELOPMENTALLY DISABLED CLIENT

BY ELNORA M. GILFOYLE, OTR., FAOTA
SPECIAL CONSULTANT

Introduction

The occupational therapy service program for an individual with a developmental disability is based upon the process of normal human growth, development and maturation. Knowledge of the growth and development process provides a framework for the evaluation of the presence and degree of dysfunction and the selection of the specific methodology and media utilized to modify the client's occupational performance skills and the components needed to achieve these skills.

The objective of the occupational therapy program is to provide the client with a means by which he/she can adapt more successfully to the environment. The goal is to facilitate the individual's capacity to achieve his/her highest level of functioning. In order to achieve this goal, the occupational therapist may use a variety of remediation/treatment methods and media. The methods and media chosen for the program are dependent upon the identified capabilities and needs of the client, the immediate and long range goals for the client, and the physical setting where the occupational therapy program will be implemented.

Although there are a variety of methods and media used in occupational therapy programs, there is the underlying commonality of the use of purposeful activity, i.e., the complete continuum of self-care, work, play, recreational, exercise, social and leisure time activities. These purposeful activities are used as the therapeutic media to facilitate a higher level of functioning so that the person can adapt to the demands of the environment.

The Role of the Occupational Therapist

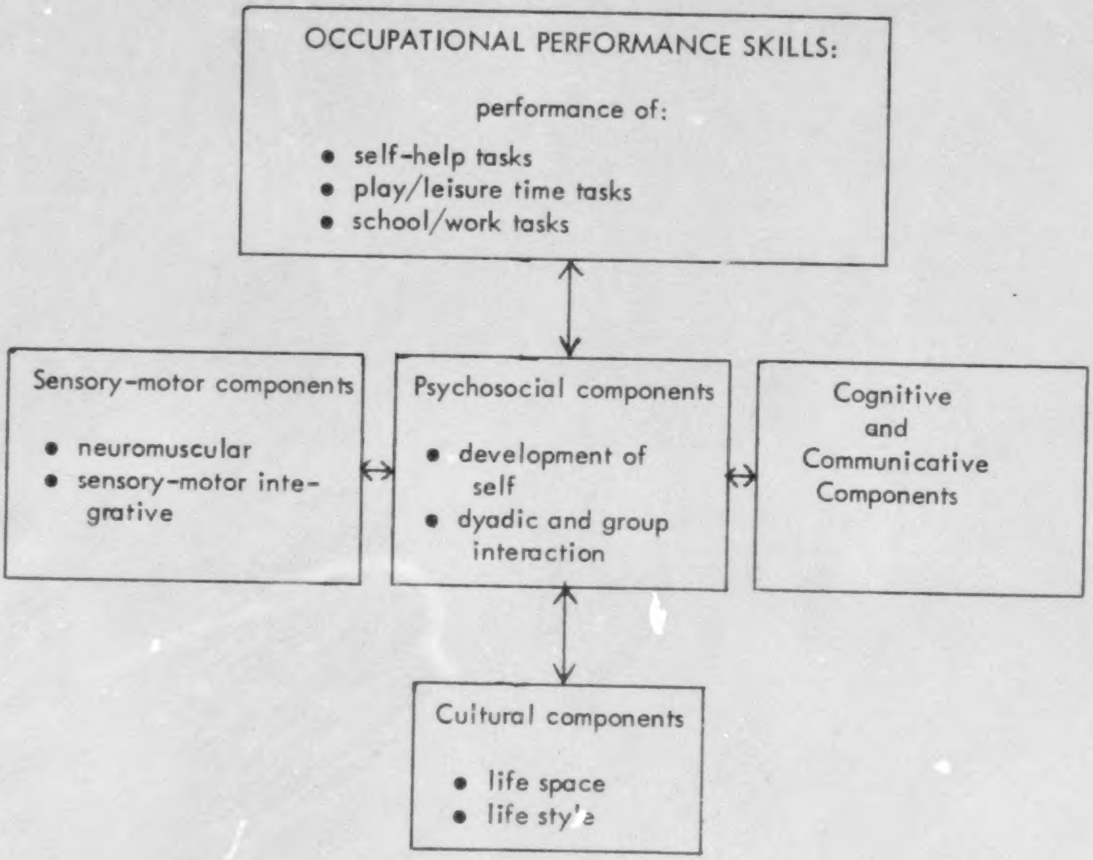
The occupational therapist has three basic and interrelated roles:

1. as an evaluator of occupational performance skills and components
2. as a planner of the occupational therapy program
3. as an implementor of the occupational therapy program

Occupational therapy services are delivered in a variety of settings, including home, school, clinic, day care centers, residential facility and public and private agencies. The occupational therapist works in cooperation and collaboration with the client, the family and other persons directly concerned with the client, i.e., teacher, physician, nurse, or psychologist. The program may be carried out on a one to one basis, i.e., client-therapist; with the client and family; or with small or large groups of clients.

A client can be referred for occupational therapy services by a physician or other persons such as psychologist, social worker, teacher, or client's family. Following the receipt of the referral, the occupational therapist evaluates the client's performance in order to identify the developmental level of occupational performance skills and components, and to determine the needs of the client.

The occupational therapy evaluation identifies the individual's level of occupational performance skills and the components needed by the individual in order to achieve these skills, i.e., neuromuscular, sensory-motor integrative and psychosocial behaviors. Because the ability to perform and function within the environment is dependent upon many aspects of behavior, the occupational therapy evaluation also considers the cognitive and communicative components and the cultural and physical environment of the individual as to their influence upon the client's performance.


OCCUPATIONAL PERFORMANCE SKILLS:
performance of:
• self-help tasks
• play/leisure time tasks
• school/work tasks
Sensory-motor components
• neuromuscular
• sensory-motor integrative
Psychosocial components
• development of self
• dyadic and group interaction
Cognitive and Communicative Components
Cultural components
• life space
• life style

The analysis of the evaluation may indicate a variety of purposes for the occupational therapy program for any given individual. Purposes may include:

A. maintenance of the present level of development

B. prevention of dysfunction, disability and/or developmental regression

C. restoration of deformity/disability

D. facilitation of development and maturation

Based upon the results of the evaluation, the therapist, in collaboration with the client and family, establishes the immediate and long range goals and plans the occupational therapy program. The program is designed to maintain and modify the behaviors of the client by facilitating a higher level of functioning. The facilitation of performance is achieved by engaging the client in a specific purposeful activity and by structuring the environment in a manner that will modify the individual's performance. It is the process used by the client in the "doing" of the activity that facilitates the desired performance.

In summary, the evaluation, planning and program implementation roles of the occupational therapist are carried out to facilitate those occupational performance skills that are developmentally appropriate for a specific individual. The facilitation of occupational performance skills is achieved by analyzing the components of behavior needed to achieve the skill and engaging the client with purposeful activity that promotes a higher level of functioning.

The occupational therapist's theoretical framework for the facilitation of occupational performance skills and components is based upon the process of normal human growth, development and maturation. In the role of facilitator, the therapist works with the client, family and significant others. In order to modify behaviors the occupational therapist must take a holistic approach by considering all aspects of the individual's behavior as it relates to the development of occupational performance skills.

The Functions of the Occupational Therapist

I. Evaluation of Occupational Performance Skills

The occupational therapy evaluation of the client's developmental level of occupational performance skills considers the sensory-motor, psychosocial, cognitive, communicative, and cultural components needed to achieve the performance skills. In addition, the evaluation considers the relationship of the components to each other and how they influence behavior.

A. Occupational performance tasks and skills are considered in three main categories:

1. self-help tasks and skills including,
    - a. feeding, i.e. ability to suck, chew, swallow, handle eating utensils and bring food to mouth; motivation and interest in feeding, ability to understand directions;
    - b. dressing, i.e. putting on and taking off garments, fastening garments such as buttons, zippers and tying shoes, obtaining and putting garments in storage areas such as drawers and closets;

c. hygiene/grooming, i.e. brushing teeth, combing and washing hair, washing and caring for body and bodily needs;

d. object manipulation, i.e. use of telephone, keys, money, watch;

e. communication, i.e. verbal abilities and breath control as related to speaking and task performance, written communication;

2. Play/leisure time tasks including:

a. stability and mobility to move within the environment, i.e. rolling, sitting, creeping, standing, walking, running, jumping climbing;

b. object manipulation tasks, i.e. the use of toys, games, reading materials, pencils, crayons, scissors, paper, recreational equipment such as balls, gloves, racquets, and bicycles;

c. psychosocial aspects such as motivation, interest, ability to get along with others, frustration tolerance, and social competence;

3. School/work tasks including:

a. perceptual-motor tasks, i.e. paper-pencil/desk activities, ability to plan movements, i.e. praxis; visual-spatial relationships for perceiving and copying forms and symbols for math, language, and reading; i.e. body schema and image; rhythmic activities; hand-eye and body-eye coordination and ability to plan gross movements in space;

b. homemaking tasks, i.e. kitchen activities such as handling cooking utensils, washing dishes, cleaning supplies and equipment, sewing, washing and ironing clothes, cleaning and dusting;

c. on-the-job tasks, i.e. typing, filing, handling equipment for job tasks.

II. Evaluation of Components

The occupational therapy evaluation considers the underlying components necessary in order for the client to achieve skilled performance with self-help tasks, play/leisure time tasks, and school/work tasks. Identifying the developmental level of components is the essential element for program planning and implementation.

A. The components are grouped in three categories:

1. sensory-motor components

a. neuromuscular, i.e. range of motion, muscle strength, muscle tone, endurance, functional use of body with numerous patterns and postures, volitional, spontaneous movement and control;

b. sensory-motor integrative, i.e. presence and influence of primitive reflexive movements upon posture and motion; presence and influence of body righting and equilibrium reactions upon posture and movement; reception and perception of sensory stimuli and the adaptive response to the stimuli; the initial sensory input, the motor output and the sensory feedback received from the motor output; body schema.

2. psychosocial components:

a. knowledge and use of self, i.e. ability to perceive self-needs, feelings, conflicts, defenses, coping behaviors, sexuality of self, self-respect, feelings of competence, acceptance of successes and failures, self-awareness, self-perception, self-concept and self-identity;

b. motivation and need-drives, i.e. anxiety/frustration tolerance; impulse control; expression of feelings; interest and concerns with self, activities and with others; defensive, submissive, aggressive behaviors to incoming stimuli;

c. dyadic interation, i.e. peer relationships, demonstrating trust, respect of another, relationships with subordinates and authority figures, perceiving and responding to another's needs and feelings; ability to cope with stress, level of interaction with objects and persons such as eye contact, touching, withdrawal, repetitive movements;

d. group interaction, i.e. sharing, cooperation, respect of others, competition, exercising group membership roles, social competence, dependency/independency gratification, ability to perceive social feedback.

3. cognitive and communicative, i.e. ability to follow instructions, verbal and written, comprehension and expression, concentration, problem solving, time management, reality orientation.

4. cultural components, life-space and life-style - including cultural and ethnic background, value orientation, family relationships and activity patterns, socio-economic status, architectural barriers, attitudes of family toward dysfunction and disability, family motivation and expectations.

B. The procedures of the evaluation process are as follows:

1. interviewing the client/family regarding the developmental history, life-style, the presenting problem(s), and the client/family objectives for the occupational therapy program.

2. observing of the client's occupational performance skills and components.

3. using test procedures such as standardized and/or non standardized

tests to identify the client's abilities and needs with occupational performance skills and components.

4. consulting with the client/family and other persons directly involved with the client, i.e. teacher, physician, psychologists, regarding the client's needs and progress.

5. analyzing, recording and sharing the findings of the evaluation with the client/family and significant others.

C. The evaluation process includes:

1. initial screening: The purpose of the initial screening process is to determine the client's general abilities and needs and to determine the suitability for occupational therapy services. Upon receiving a referral, the occupational therapist collects and compiles information from the referring source, the client/family and other pertinent information such as medical, psychological and school records. The therapist reviews and analyzes the information to determine the suitability for occupational therapy services, to select those developmental behaviors which should be further screened and/or evaluated by the occupational therapist and to select those screening/evaluation procedures to be used.

The initial screening procedures may include personal or telephone interviews with the client/family; observation of the client's performance with a few selected skills; standarized and/or non-standardized screening tests in order to establish the need for more in-depth evaluation and the types of procedures to be used.

The data obtained from the initial screening process is summarized and the occupational therapist formulates recommendations regarding further evaluation and/or types of services which will meet the client's needs. During the initial screening process, the therapist may establish that the client would benefit from the services of another specialist. The therapist takes the responsibility to contact the client/family and refer them to another more appropriate source.

When the client is accepted for further evaluation, the therapist establishes the amount of time and cost for conducting the evaluation and contacts the client/family to schedule an appointment. In addition, the therapist explains the formative evaluation to the client/family, i.e. what will be done and why, what information will be obtained, and the time and cost. Should financial assistance or transportation be needed, the therapist refers the client/family to the appropriate source.

The therapist contacts the initial referring source to inform them of the contacts with the client/family and the plan for programing further evaluation. The therapist maintains all necessary records of the initial evaluation findings.

2. formative evaluation: the purpose of the formative evaluation is to provide:
   - a. an in-depth understanding of the client's developmental level of occupational performance skills and components;
   - b. a baseline of functional abilities to measure the client's progress;
   - c. the information necessary in order to determine client needs, program goals, methods and media to be used;
   - d. pertinent information that is significant to the total health care program for the client.

   Prior to the scheduled appointment with the client, the therapist selects and prepares the necessary materials and equipment to be used during the evaluation. The therapist reviews the procedures to be used and organizes materials in order to conduct the evaluation appropriately and accurately.

   Following the completion of the formative evaluation, the therapist reviews, analyzes and synthesizes the data. The findings are recorded and discussed with the client/family. The written report of the formative evaluation includes the referral information, procedures used, standarized test scores, findings from interviews and observations by therapist, interpretation of test/evaluation results, and recommendations for occupational therapy services.

Upon receiving written permission from the client/family, the therapist shares the results of the evaluation with the referring source and significant others. The interpretation of the evaluation may be shared verbally in conferences and/or by a written report. The therapist records in the appropriate records the dates, discussion and interpretation of all conferences related to the evaluation results.

3. re-evaluation: The purpose of the re-evaluation process is to provide the therapist and client/family with a means to measure change and effectiveness of the occupational therapy program. The re-evaluation process may include the informal review of progress notes written and observations made during the treatment/rehabilitation program. In addition, the therapist may assess the client's progress and appropriateness of the methods and media being used by periodically repeating the formative evaluation process.

The occupational therapist recommends discontinuation of the program when the services are no longer needed, feasible, or beneficial. When appropriate, the occupational therapist is responsible for developing a follow-up plan which includes referral to other agencies, programs or personnel as needed.

III. Program Planning

The purpose of the program planning process is to establish the immediate and long range goals for the occupational therapy program with the client, and to determine the methods and media most appropriate for accomplishing the determined goals.

A. Goal setting:

The results of the evaluation process are utilized by the therapist to establish the immediate and long range goals. Goals are established collaboratively with the client/family and with other persons working with the client. The over-all goal for the occupational therapy program is the facilitation of an individual's capacity to achieve his/her highest level of sensory-motor, psychosocial, cognitive, communicative, functioning so that the individual can maximize functioning demands of the environment. Program goals to maximize functioning may include maintenance of the current functional level; prevention of dysfunction; restoration of functioning; and facilitation of higher developmental levels of performance. Goals are based on the client's current and potential level of occupational performance skills; components needed to achieve occupational performance skills; assessment of the future course of the disease, disability or developmental lag; and the previous and predicted life-style and life-space of the client/family.

Goals for the program are recorded in appropriate records and shared with the client/family and significant others. Program goals may be modified as the need arises or as results from the re-evaluation process indicates.

B. Selection of methods and media:

The therapist selects the methods and media to be used in order to accomplish the established goals. In addition to being related to specific goals to be achieved, the selection of the methods and media is dependent upon the:

1. therapist's knowledge and competence level with the specific method/media;

2. availability of supervision/consultation for the therapist when needed regarding specific method/media;

3. client's interest, motivation, age, and developmental level;

4. client's developmental occupational role tasks, i.e. infant, preschooler, student, homemaker, or worker;

5. physical setting for the occupational therapy program;

6. availability of equipment/supplies.

Following the selection of the method/media, the therapist records the program plan in the appropriate records. The methods/media may be modified during the implementation program according to the determined changes in the client's performance and according to the effectiveness of the methods/media.

IV. Program Implementation

Program implementation is the process of utilizing intervention methods and media in order to achieve the established goals. The program will include a variety of purposeful activities and therapeutic methods to maximize development, maturation and independence of occupational performance skills and components needed to achieve those skills. The major emphasis of the program is the development and maturation of the components of the skill so that the individual can attain the occupational performance skill.

A. The functions of the occupational therapist during the implementation process may include the performance or supervision of any or all of the following tasks:

1. scheduling client/family for program services

2. preparing of equipment, supplies, environmental setting for client use

3. escorting client/family to program setting

4. orientating and instructing client/family regarding the methods/

media being used

5. facilitating participation of client/family with method/media

6. structuring/adapting/modifying environment to meet client/family needs

7. observing/supervising client's performance

8. analyzing/summarizing client's performance

9. discussing performance with client/family and significant others

10. recording performance, analysis, observations in appropriate records

11. designing and constructing adaptive equipment that is needed

12. ordering adaptive equipment and orthotic/prosthetic devices that can be purchased and are needed by the client

13. designing and constructing orthotic devices that are needed and that can be made by the therapist

14. orienting and instructing client/family regarding the use and care of devices and adaptive equipment

15. orienting and instructing other personnel that may be involved with the program

16. determining need for re-evaluations

17. coordinating program with other services

18. maintaining setting, equipment and supplies in proper condition

19. preparing home program for client/family in order to carry out program between scheduled appointments

20. orienting and instructing home program to client/family

21. referring client/family to appropriate sources for assistance with transportation and finances for program implementation

B. Examples of methods that might be utilized by the occupational therapist during program implementation include:

1. positioning and dynamic patterns of postures and movements

2. controlled, therapeutic sensory stimulation, i.e. use of objects, equipment for tactile, visual, auditory, vestibular, proprioceptive

input, followed by dynamic patterns of movements

3. graded motions and resistance
4. muscle re-education
5. neuromuscular facilitation
6. education in the use of adaptive equipment
7. education in the use of orthotic and prosthetic devices
8. task oriented groups
9. therapeutic role models
10. role playing
11. behavior modification
12. positive/negative reinforcement
13. assuming surrogate role

14. functioning as the alter ego

15. confrontation

16. interpretation

C. Examples of media that might be used during program implementation:

1. toys and play activities of children

2. music, games, sports, playground and gym activities

3. arts and crafts

4. educational activities

5. self-help activities

6. home-care activities

7. actual job-tasks, simulation of job-tasks

8. social-interpersonal activities

V. In summary, the functions of the occupational therapist include a variety of tasks to carry out the roles of evaluator, planner and program implementor. The therapist should accurately and appropriately carry out the tasks to benefit the client's development of occupational performance skills and the components needed to achieve those skills. The functions related to the evaluation process determine the client's abilities, needs and progress. The functions related to the planning process determine the therapeutic goals and methods/media to be used to accomplish the goals. The functions related to the implementation process include the actual usage of treatment/rehabilitation methods and media. The occupational therapist functions to maintain, modify and facilitate developmental behaviors for the client so that the client may effectively adapt to the demands of the environment.

This document was prepared under the auspices of the AOTA-HEW Continuing Competency Contract # NOI-AH-44116. The document was prepared as a frame of reference for the development of standards of occupational therapy practice for the treatment of the developmentally disabled client. The document was prepared solely for the purposes of this contract and is not an officially approved AOTA document at this time.

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Clarification of Terms used in the Description of the Roles and Functions with the Client with a Developmental Disability

1. A developmental disability is the result of any condition, deprivation or disease (congenital, acute, progressive or chronic) which interrupts or delays the sequence and rate of normal growth, development and maturation.

2. The developmental process is the manner, rate, and sequence of acquiring behaviors (i.e. sitting, standing, dressing one's self, self-awareness/ identity; social relationships with peers and adults.)

3. Growth is the biological/structural changes of the body (i.e. skeletal/ muscular changes).

4. Development is the change and modification of the bodily processes in performing behaviors and adapting to the environment.

5. Maturation is the modifications within the individual's neurophysiological systems.

6. Dysfunction is the inability to effectively perform and interact with the environment.

7. Methodology is the mode, procedure, style, technique and sequence utilized by the occupational therapist to accomplish an established purpose or goal.

8. Media is the use of an activity, objects, self or others in the occupational therapy program to accomplish a specific goal.

9. Occupational performance skills are those behaviors and practical abilities which an individual uses to perform self-care, school/work and play/ leisure time activities.

10. Components of occupational performance skills are those biological, psychological and cognitive processes utilized to accomplish occupational performance tasks. The components include sensory-motor, psychosocial, cognitive and communicative functioning and the cultural and physical environment.

11. Environment is the mileau, setting or surrounding, including the individual and others within the setting, the earth, space and objects within space. Environment is that with which an individual interacts.

12. Purposeful activity is any activity utilized to accomplish a specific purpose or goal. The therapeutic purpose or goal to be accomplished is inherent within and autonomous to the nature of the activity. The process used in "doing" the activity is the therapeutic purpose or goal.

13. Treatment is the modification of the biological and psychological processes or functional components of behavior.

14. Rehabilitation is the process of developing within the individual a more effective way of coping with the demands of the environment.

THE ROLE AND FUNCTIONS OF THE OCCUPATIONAL THERAPIST IN THE TREATMENT OF THE PHYSICALLY DISABLED CLIENT

BY NANCY PRENDERGAST, M. Ed., OTR
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The Role of the Occupational Therapist

Physical disabilities may result from disease, trauma, congenital abnormalities, disuse, or degenerative processes. Occupational therapy is a service provided to the client for the purpose of determining functional capacities and developing the necessary functioning and skills for performance regardless of the client's age, role, or disability.

In treating the physically disabled client, the role of the occupational therapist as a direct service practitioner is to provide a program designed to develop, restore or maintain performance abilities in tasks necessary for independent and satisfying daily living. The occupational therapist is concerned with the home, family and community environments in which the client must live and function in his or her role as a child, student, worker, homemaker, or retired person.

Occupational therapy services may be provided in the home, hospital, rehabilitation center, out-patient clinic, special school setting, nursing home, or work environment.

The Functions of the Occupational Therapist

Through client/family interviews, subjective and objective testing, observation of client performance, review of records and other informational sources, the occupational therapist evaluates the client's functional skills and performance capacities in the areas of self-care (feeding, dressing, hygiene, grooming, object manipulation), work (school, home and family management, employment), and play/leisure (games, sports, hobbies, social activities). These areas are collectively referred to as "occupational performance".

The ability of the client to perform these self-care, work and leisure tasks depends not only upon the adequacy of the functional skill itself, but also upon the adequacy of underlying performance components which include motor functioning, sensory-integrative functioning, cognitive functioning and psychosocial functioning. Therefore, these specific components and their functional capacities are evaluated as well.

Evaluation of motor functioning may include range of motion, gross muscle strength, muscle tone, functional use, gross and fine motor skills. Evaluation of sensory-integrative functioning may include assessment of body schema, posture, body integration, visual-spatial relationships, sensory-motor integration, reflex and sensory testing. Cognitive functioning is assessed through an evaluation of ability to comprehend written and verbal communication, concentration, memory and recall, ability to problem solve, time management, conceptualization, and integration of learning. Evaluation of psychological functioning may include determination of emotional states and feelings, coping behaviors and defenses, self-identity and self-concept. Social functioning is assessed through observation of one-to-one and group interactions.

Architectural barriers and social attitudes relative to the client's environment and life style are examples of other areas the occupational therapist must consider in the evaluation, as such areas may also affect the client's ability to function.

Based upon the evaluative data obtained, the therapist identifies performance capacities and deficits and proposes a program to develop, restore and/or maintain function. The program plan consists of short and long term goals, activities and resources to be utilized, and wherever possible should be mutually established with the client. Collaborative goal-setting assures that the program is directed toward the client's return to an environment and life style which will be manageable, beneficial and desireable.

The specific activities, techniques and modalities selected to implement the program should be realistic and relevant to the client's needs and based upon accepted theories of treatment and sound management rationale.

In occupational therapy programs to restore, develop, or prevent deterioration of occupational performance and performance components, the therapist implements the program or supervises others in the implementation of the program; supervises the design and construction of adaptive equipment; instructs the client in the use of adapted methods equipment, work simplification techniques, and prosthetic/orthotic devices as needed.

After implementation of the occupational therapy program, periodic re-evaluation of occupational performances skills and component functioning is performed to determine appropriate program changes. This process increases the validity of specific goals and continuing effectiveness of the total occupational therapy program. The therapist reports on client performance and coordinates the occupational therapy program with other disciplines and services.

The occupational therapist recommends discontinuation of occupational therapy services when the client has received optimal benefit from the program. The occupational therapist's determination of optimal benefit is based on both objective and subjective findings, and also to such factors as the cost of the program, the client's time and financial resources.

At the time of discontinuation, the occupational therapist makes a final assessment of the client's status which includes the client's response to the program, reasons for discontinuation, goals and objectives achieved and, when possible, reasons for the client reaching a level of performance beyond or below the level expected. Where appropriate, the therapist also makes recommendations for follow-up and/or referral to other agencies and services.

Proper documentation by the occupational therapist occurs during the entire process of evaluation, program planning, implementation and re-evaluation. This includes acknowledgement of the initial referral to occupational therapy, evaluative findings, program plans, progress reports and discontinuation or discharge summaries.

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THE ROLE AND FUNCTIONS OF THE OCCUPATIONAL THERAPIST IN THE TREATMENT OF THE STROKE CLIENT

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The Role of the Occupational Therapist

The role of the occupational therapist in the treatment of stroke patient as a provider of specific services is to aid the client in achieving his/her highest level of function in self care, work, and leisure activities. The client's performance in these three basic areas of activity is referred to as "occupational performance". Towards the goal of optimal occupational performance, the occupational therapist develops a specific therapeutic program based on the client's motor, cognitive, sensory-integrative, psychological, and social functioning. The occupational therapist also works as a team member with other health practitioners toward shared common treatment goals, and considers the personal goals of the client and involved family members. To achieve this, the therapist works as an evaluator, treatment planner and implementor, team member, supervisor and, at times, researcher.

The Functions of the Occupational Therapist

The functions performed by the occupational therapist in providing direct services to the stroke patient include:

I. Evaluation

Based on the client's physical and cognitive abilities the therapist decides if evaluation in the following areas will be complete or partial.

A. Evaluation of Occupational Performance Skills

1. Self-care skills: The therapist uses specific tests and observation of the client in the physical environment as well as interview with the client and family and information from other team members to evaluate abilities and limitations for performing the following: self-feeding, grooming, dressing, bathing, functional hand activities (e.g., striking a match, handling money, winding a watch), and communication skills (e.g., writing, telephoning).

   The therapist categorizes the client's performance in each activity as: dependent; requiring physical assistance; requiring verbal instruction or demonstration; requiring supervision or independent.

   The therapist attempts to identify factors preventing independent function. The therapist also indicates pertinent details about the physical set-up at time of evaluation (e.g., activity attempted by client in wheelchair, while ambulatory with or without device).

2. Work skills: The therapist evaluates the client's abilities and limitations in performing tasks required as a homemaker (e.g., meal planning and preparation, house cleaning, laundry, marketing), student, or employee. The therapist evaluates sitting and standing tolerance, mobility, workmanship, work habits, organization, and planning abilities. The need for adapted methods which may assist

the client in work performance is evaluated.

3. Play-leisure Skills: The therapist evaluates the client's interests and skills in performing play/leisure activities; e.g., games, sports, hobbies, and social activities. The therapist and client consider which leisure activities can be maintained and which must be discontinued because of the disability. The therapist assists the client in identifying substitute interests and activities.

B. Evaluation of the Components of Occupational Performance Skills

1. Motor Functioning: The therapist evaluates the client for normalities and abnormalities in passive range of motion, voluntary motion, endurance, muscle tone (e.g., flaccidity, spasticity), balance, coordination, dexterity, and gross muscle strength. Where abnormalities are identified the therapist describes the extent. The therapist uses this information to determine functional use of the upper extremity (i.e., ability and degree of skillfulness) and to identify the presence of physiological problems which may limit or hinder rehabilitation.

2. Sensory-Integrative Functioning: The therapist evaluates the client's abilities and limitations in perceiving and integrating tactile and visual input as well as information about his/her own body. To this end the therapist evaluates proprioception, stereognosis, touch, localization, and hot-cold sensation; vertical and horizontal perception, left-right

discrimination, spatial relations, and depth perception; attending to body and space on the affected side, body part recognition, and body image.

3. Cognitive Functioning: The therapist evaluates abilities and limitations in written and verbal communication, comprehension, problem-solving, conceptualization, integration of learning, time management, concentration, judgement and safety consciousness. This is done through observation of the client performing an activity. In addition, the therapist uses information from other informed sources; e.g., speech pathologist, psychologist, family.

4. Psychological and Social Functioning: The therapist evaluates the client's ability to accept and profit from treatment. Toward this end the therapist is alert to the client's level of self esteem, body image, and adjustment to the situation. Information about the client's attitudes and social relationships prior to the stroke is sought.

C. Assessment of Cultural and Physical Environment

1. Cultural: The therapist considers the client's social-cultural life setting, the values of that setting, and its perception and acceptance of disability. Socio-cultural values are often of critical importance in terms of the client's motivation to participate in a rehabilitation program. In evaluating this area the therapist uses observation,

discussion, and interview with the client and family as well as consultation with other treatment team members.

2. Physical: The therapist determines the client's probable future environment through discussion with client, other team members or family. The therapist is then able to evaluate by interview or home visit the need to rearrange furniture, adapt storage facilities, and eliminate architectural barriers.

II. Program Planning

After evaluation of the client's abilities, the therapist carefully decides which areas of dysfunction will be treated first, hoping to formulate challenging yet attainable goals for the client. Treatment program planning includes setting long and short term goals and selection of activities, techniques and equipment. The scope of disability frequently calls for a treatment program in stages; some more complex areas of dysfunction may be noted but not treated until the client demonstrates that he/she will benefit from treatment in that area. Whenever possible the therapist reviews evaluation findings with the client to determine joint rehabilitation goals and establish a treatment program plan and sequence.

A. For the Restoration and Maintenance of Occupational Performance Skills

1. Self-Care Skills: The primary goal is to retrain the client in activities

of daily living in order to obtain the maximum level of functioning independence. The therapist selects the most appropriate techniques for the client's mastery of these activities. The therapist considers these techniques: client using only the unaffected side of the body, client using the affected side of the body in an assistive or dominant capacity, client receiving training in the use of adaptive devices e.g., a stabilized nailbrush for cleaning the nails of the non-affected hand. The basic training in feeding, grooming, dressing, bathing, toileting, hand and communication skills often must be accompanied by training to facilitate sitting and standing balance, to improve functional use of both the affected and unaffected extremity, and/or to improve cognitive functioning. When language deficits exist the therapist helps client find ways to express his/her basic needs.

2. Work Performance Skills: The primary goal is to facilitate the client's ability to return to work or homemaking tasks where possible. The therapist may plan to teach one-hand techniques, energy saving techniques, and/or mobility skills in homemaking areas such as child care, cooking, cleaning and in other vocational settings when indicated. The therapist might make recommendations to modify/adapt the physical environment as needed.

3. Play/leisure Skills: The primary goal is to provide and develop avocational interests and activities. The therapist helps the client

to develop skills or techniques needed for restoring/maintaining leisure activities or learning new ones.

B. For the Restoration and Maintenance of Occupational Performance Skill Components

1. Motor Functioning: Through the use of activities and adapted equipment, the goals for the affected side are to prevent and correct deformities, facilitate return of function, strengthen muscles, improve sensorimotor function, and reduce pain and swelling. Activities to increase passive range of motion, teach the client range of motion techniques to be done by himself/herself, and decrease spasticity are used as well as muscle re-education activities and techniques to facilitate return of function. The therapist may prescribe appropriate positioning equipment to achieve these goals. The goals of therapy for the unaffected extremity is to increase dexterity when necessary, particularly when this is the non-dominant side.

2. Sensory-integrative Functioning: The primary goals are to teach compensation for tactile and visual deficits and retrain in body image.

3. Cognitive Functioning: The primary goal is to facilitate improvement of

concentration, problem-solving, time management and conceptualization skills.

4. Psychological and Social Functioning: The primary goal is to help the client develop positive feelings of self-worth despite any residual disability or change in life style precipitated by the stroke. The therapist often uses group and family activities to facilitate social interaction.

C. Cultural and Physical Environments

1. Cultural: The therapist selects activities and treatment modalities which will not conflict with the client's value structure or social mores and are appropriate for the life style to which the client will be returning. The therapist assists the client in recognizing the options that society offers and helps the client to make choices appropriate to his/her needs and abilities.

2. Physical: The primary goal is to recommend and/or make modifications in the physical or architectural home/work environment to allow the client to function more effectively and safely e.g., storing items in easily accessible places, utilizing grab bars in the bathroom. The therapist assists the client in developing the skills needed to expand his/her physical environment and perceive it in a non-threatening

manner.

III. Program Implementation

Prior to the initiation of treatment in any area of dysfunction, both the client and his family should be oriented to the activities and processes to be used. Program goals and objectives should be clearly stated and agreed upon by all parties.

A. Treatment for Restoration and Maintenance of Occupational Performance Skills.

1. Self-care Skills: The therapist assists the client in relearning activities of daily living with the use of work simplification, one-handed techniques, incorporating the affected extremity in bilateral tasks, adapted equipment, energy conservation techniques, and repetitive practice. If adapted equipment is necessary the therapist takes steps for the client's procurement of equipment. The therapist may instruct the client or family in the selection of clothing which simplifies one-handed dressing. The therapist advises the client or family on resources for replacing adapted equipment and instructs and/or informs family about the client's self care skills as well as principles of work simplification and energy conservation.

2. Work Skills: The therapist uses activities to increase the client's manual dexterity, endurance, and functional capacities for work

activities. The therapist instructs the client in the use of techniques, principles and adapted equipment helpful to the student, homemaker, or worker. The client may practice skills needed for work performance such as hand skills needed for cooking, cleaning, typing, filing, using machinery etc. The therapist observes the client working in a kitchen or other simulated work setting, and teaches safety factors and trains in work simplification and energy conservation when indicated.

3. Play/leisure Skills: The therapist explores areas of interest with the client and suggests resources for recreational and avocational activities, helps the client plan his/her total day, and helps the client develop skills needed to participate in available community programs.

B. Treatment for the Restoration and Maintenance of Occupational Performance Skill Components.

1. Motor Functioning: The therapist prevents deformity and facilitates the return of function to the affected extremity by teaching positioning techniques with the use of pillows, handrolls, handsplints or slings in bed or wheelchair and by teaching passive range of motion techniques for maintaining joint range. The therapist uses graded passive, assistive, active, and resistive exercises and/or activities as appropriate to increase strength. Neuro-muscular facilitation techniques, reflex patterns, and muscle re-education can be used to facilitate return of muscle function. While the affected side remains non-functional the

therapist trains the client to use the unaffected extremity as a dominant extremity by introducing repetitive, graded, and increasingly complex activities.

2. Sensory-integrative Functioning: The therapist uses a variety of sensory activities and techniques to teach compensation for and encourage awareness of sensory deficits for the client's protection, especially to temperature and position of the affected part. The therapist provides activities to improve eye-hand coordination, figure-ground discrimination, right-left discrimination, and spatial relations. The therapist also uses activities to teach the client awareness of body parts. The therapist tries to improve client's awareness of these problems.

3. Cognitive Functioning: The therapist provides the client with activities to orient him/her to time, place, and person to increase concentration and attention span. The therapist provides the client with activities e.g., crafts, games to challenge and improve problem-solving abilities and conceptualization skills. The therapist informs the client about his/her time management and work habits and suggests methods for improvement.

4. Psychological and Social Functioning: The therapist may use group

activities for mutual psychological support and the exchange of helpful suggestions and ideas. Activities which allow for expression of emotions of depression, anger etc. may be used to facilitate emotional adjustment. The therapist helps the client to focus on and exercise those abilities that are present, in that way helping the client form a basis for a positive self image.

C. Cultural and Physical Environment

1. Cultural: The therapist works with the family to foster understanding of the client's capabilities and encourage carry-over of progress made in treatment after discharge.

2. Physical: After visiting or evaluating the client's home by interview, the therapist may help plan any necessary modifications, reorganize work areas, and plan for self-help equipment. This may include acquainting client or family with variations in types of adapted equipment recommended, suggesting sources for procurement, obtaining physician's prescription, and referring to proper personnel for financial assistance. The therapist also may help a client learn the use of the local transportation system.

IV. Re-evaluation

The occupational therapist assesses the client at regular intervals to determine appropriate changes in program and recommends discontinuation of occupational therapy services when the client has received optimal benefit from the program. At the time of discontinuation, the occupational therapsit makes a final assessment of the client's status which includes the client's response, objectives met, reason for discontinuation and, when possible, reasons for reaching a status above or below the expected goals. When appropriate and feasible, the occupational therapist is responsible for follow-up after discontinuation.

V. Recording and Reporting

The therapist records the results of the evaluation on an appropriate form in the medical record and records the results of any treatment given at regular intervals. When changes occur, the therapist documents them accordingly. When the client is ready for discharge, the therapist summarizes and records results of the treatment program. The therapist also may provide a home program for the client after discharge or may refer client for outpatient treatment or referral to other community health agencies if necessary.

This document was prepared under the auspices of the AOTA-HEW Continuing Competency Contract # NOI-AH-44116. The document was prepared as a frame of reference for the development of standards of occupational therapy practice for the treatment of the stroke client. The document was prepared solely for the purposes of this contract and is not an officially approved AOTA document at this time. January, 1976

THE ROLE AND FUNCTIONS OF THE OCCUPATIONAL THERAPIST IN THE TREATMENT OF CLIENTS WITH ARTHRITIS OR RHEUMATIC DISEASE

BY VIRGINIA A. STILLMAN, OTR.
SPECIAL CONSULTANT

The Role of the Occupational Therapist

The role of the occupational therapist in the treatment of clients with arthritis or rheumatic disease is to assess the health and rehabilitation needs of the client and provide a therapeutic program to improve the client's ability to function in self-care, mobility, leisure time, and life role activities; e.g., as an employed worker, homemaker, pre-schooler, student or retired person.

The following statement of objectives and functions is intended as a basic guideline for the establishment of standards of practice for occupational therapists providing treatment to clients with arthritis and other rheumatic diseases. Many variables influence the extent and type of treatment provided; e.g., the type and presenting phase of the client's disease, the unique needs of the client, the nature of the health facility employing the services of the occupational therapist, the needs of the community being served, and other health care resources available.

The Objectives and Functions of the Occupational Therapist

I. Evaluation

Objective: Determine client's need for occupational therapy intervention to prevent or minimize the disabling effects of the disease process, restore or maintain function, or assist in adaptation to loss of function.

Functions:

A. Gather subjective and objective information pertaining to the client from the written referral, client's medical record, and findings of other health professionals.

B. Orient client to the rationale for occupational therapy evaluation procedures.

C. Interview client to assess client's understanding of and attitudes toward the disease process, personal values and goals, and interpersonal relationships with family members and/or significant others.

D. Evaluate client's physical status by the following procedures:

   1. Measurement of active and passive motion of joints affected by disease process, and muscle strength, including pinch and grip.

   2. Examination of joints and para-articular structures for abnormal conditions; e.g., pain, instability, deformity, swelling,

   3. Test client's functional limitations, abilities, and tolerance in the areas of self-care, mobility, leisure time, and life role activities.

E. Evaluate client's living and working environment by a detailed interview and/or site visits to identify physical and social problems and resources available to client.

II. Program Planning

Objective: Plan an occupational therapy program to meet the client's needs as identified by the evaluation.

Functions:

A. Determine realistic short and long term goals jointly with client.

B. Determine specific objectives for treatment; e.g.,

1. Educate client in knowledge of the disease process, its effect on normal body functions, and methods of therapeutic intervention through occupational therapy.
2. Prevent or minimize the disabling effects of the disease process; e.g., deformity, pain, loss of functions,
3. Maintain and/or increase range of motion, strength, and tolerance to activity.
4. Improve client's functional ability in self-care, mobility, leisure time and life role activities.
5. Improve the client's ability to meet the social and emotional stresses imposed by the disease process; e.g., changes in body image and self concept, fear of deformity and dependence, limitations placed on interpersonal relationships and sexual activities.

C. Determine treatment methodology, priorities, and rationale for attaining stated goals and objectives.

D. Determine durations, frequency, and expected outcome of treatment.

E. Refer to other health professionals and/or agencies those client needs which cannot or need not be met by the occupational therapist.

III. Program Implementation

Objective: To provide treatment which will achieve goals and objectives stated in the program plan.

Functions:

A. Orient the client to the rationale for treatment methods utilized.

B. Utilize treatment methods appropriate to the client's needs and problems; e.g.,

1. Instruct client in exercises and/or functional activities which maintain or improve motion and strength.
2. Design, fabricate and/or fit splints for the purposes of joint rest, protection, improved function, preoperative evaluation, or post-operative management. Instruct client in use, care and contra-indications of splint provided.
3. Instruct client in principles of joint protection, including:
   a. proper body mechanics.
   b. avoidance of stressful or deforming postures and activities.
   c. energy conservation and work simplification techniques.
   d. need for proper balance of rest and activity.
   e. methods of relaxation.
4. Introduce methods of adaptation in performing self-care, mobility, leisure time, and life role activities;

a. Teach, or assist client to find, alternative methods or performing activities.

b. Adapt, or provide assistive equipment.

c. Modify home and/or work environment.

5. Inform client of community resources available in the areas of vocation, avocation, transportation, socialization and counseling.

6. Assist client to develop skills to meet the social and emotional stresses imposed by the disease process.

7. In childhood diseases, advise client's family and teachers about activities appropriate to the child's developmental level.

8. Provide a written home program and instruct client in rationale, execution, and precautions.

C. Re-evaluate client's status periodically during the treatment process, and alter program when change in client's condition warrants.

D. Re-evaluate goals and objectives of program plan, and revise as needed.

E. Discontinue client from occupational therapy program when goals are achieved, or other valid reason is given.

F. Establish plan for occupational therapy follow-up, and recommend referral to other services when needed.

IV Collaboration

Objective: To insure coordination and continuity of health care in meeting client's needs.

Functions:

A. Coordinate the occupational therapy program with other health services, appropriate family members, employer, friends, and community agencies.

V Documentation

Objective: To record in legible, accurate and retrievable form, information pertaining to the client.

Functions:

A. Record the following information in the client's medical record and occupational therapy record.

1. Referral for occupational therapy treatment and date received.
2. Occupational therapy evaluation including date, objective and subjective findings, and identification of client's needs.
3. Occupational therapy program plan including short and long term goals, objectives, treatment methods, and expected frequency, duration and outcome of treatment.
4. Progress notes at regular intervals indicating client's response to treatment and changes in client's condition.
5. Findings of periodic re-evaluations of client's status and reasons for change in treatment.
6. Evidence of periodic re-evaluation of program plan, goals and objectives, and revisions if warranted.

7. Discharge summary including date and reason for discharge, client's status and goals achieved, and plans for occupational therapy follow up.
8. Evidence of coordination with other health services.

VI Continuing Education

Objective: To maintain a current knowledge base of disease processes, evaluation procedures, treatment methodology and resources.

Functions:

A. Assume responsibility for meeting one's own continuing education needs in the field of arthritis and rheumatic diseases.

This document was prepared under the auspices of the AOTA-HEW Continuing Competency Contract # NO1-AH-44116. The document was prepared as a frame of reference for the development of standards of occupational therapy practice for the treatment of the client with arthritis or rheumatic disease. The document was prepared solely for the purposes of this contract and is not an officially approved AOTA document at this time. January, 1976.

GLOSSARY OF TERMS USED IN THE OCCUPATIONAL THERAPY STANDARDS OF PRACTICE[1]

1. Abnormal patterns of motion (synergies): certain primitive patterns of motion which typically appear to varying degrees in the hemiplegic individual when isolated movement is attempted. These patterns may be seen in the extremities in stereotyped flexion and extension patterns as distinguished from normal, coordinated, voluntary motion which is also synergistic in nature.

2. Activities of daily living: (see definition of occupational performance.)

3. Activity restriction: The exclusion of certain activities, or restrictions in method or duration of performance.

4. Assistive/adaptive equipment: a special device which assists in the performance of self care, work or play/leisure activities or physical exercises.

5. Cognitive skills: the level, quality, and/or degree of comprehension, communication, concentration, problem solving, time management, conceptualization, integration of learning, judgment, and time-place-person orientation.

6. Community services, programs or resources: vocational, social, religious, recreational, health, education and transportation services or programs that may be available in the community.

7. Coordination: the ability to perform motions in a smooth concerted way.

8. Dexterity: skill and ease in performing physical activities.

9. Document: the written recording of information in the client's overall record/chart and/or in the occupational therapy record/chart.

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[1] This glossary has been prepared by occupational therapists working under the auspices of the AOTA Continuing Competency Program and the AOTA-HEW Continuing Competency Contract NO1-AH-44116. This glossary is not an AOTA official glossary. Any questions regarding the use of the glossary should be directed to the AOTA Director of Certification. January 1976

10. Evaluate/evaluation: the process of collecting and interpreting data obtained through observation, interview, record review, or testing.

11. Environmental adaptations: structural or positional changes designed to facilitate independent living and/or increase safety in the home, work or treatment setting; i.e., the installation of ramps, bars; change in furniture heights; adjustment of traffic patterns.

12. Facilitation techniques: specific treatment which attempts to encourage motion in a non-functioning muscle or muscle group.

13. Inhibition techniques: specific treatment which attempts to decrease muscle tone or excess motion that interferes with function.

14. Joint protection/preservation: the principles or techniques of minimizing stress on joints. Includes the use of proper body mechanics; avoidance of excessive weight-bearing, static, or deforming postures.

15. Kinetic activities: those activities requiring motion. Can include activities of daily living and isometric, assistive, resistive exercises.

16. Life space: an individual's cultural background, value orientation, and environment.

17. Life style: the degree, range and balance of self care, work, and play/leisure activities.

18. May: indicates an acceptable method that is recognized, but not necessarily preferred.

19. Motor skills: the level, quality and/or degree of range of motion, gross muscle strength, muscle tone, endurance, fine motor skills, and functional use.

20. Occupational performance: the performance of self-care, work and play/leisure activities, the activities of daily living. The performance of these activities requires self-care, work, and play/leisure skills. The concept of occupational performance is further described in the delineation of roles and functions in Appendix V.

21. Performance components: the learned and developmental patterns of behavior which are the prerequisite foundations of self care, work, and play/leisure skills.

    The performance components include:

    a. Motor skills
    b. Sensory-integrative skills
    c. Cognitive skills
    d. Psychological/intrapersonal skills
    e. Social/interpersonal skills

22. Play-leisure skills: those skills necessary to perform and engage in activities such as games, sports, and hobbies.

23. Positioning: the placing of body parts in proper alignment.

24. Psychological/intrapersonal skills: the level, quality and/or degree of self-identity, self-concept, and coping skills.

    a. self-identity and self concept: the ability to perceive self needs and expectations from those of others; identify areas of self-competency and limitations; accept responsibility for self; perceive sexuality of self; have self respect; have appropriate body image; view self as being able to influence events.

    b. coping skills: includes the ability to subliminate drives, find sources of need gratification, tolerate frustration and anxiety, experience gratification, and control impulses.

25. Reality orientation: the treatment approach aimed at reinforcement of reality, i.e. the use of simple, structured activities for orientation to time, place, and person.

26. Self care skills: skills such as dressing, feeding, hygiene/grooming, mobility, and object manipulation.

    a. mobility: skills such as getting in/out of bed, chair, wheelchair, vehicles and utilizing transportation.

    b. object manipulation: skills such as the handling of common objects such as telephone, keys, money, light switches, doorknobs.

27. Sensation: perception of stimuli, includes touch, pain, temperature, stereognosis, proprioception, taste, smell, kinesthesia, vision, hearing.

28. Sensory-integrative skills: the level, quality, and/or degree of body schema, praxis, posture and body integration, visual-spatial relationships, sensory-motor integration, reflex and sensory status.

29. Shall or must: indicates a mandatory statement; the only acceptable method.

30. Should: indicates the commonly accepted method, yet allows for the use of effective alternatives.

31. Significant others: persons who have an important relationship to the client. This could include the client's family, friends, employer, teacher, or other health care providers.

32. Social/interpersonal skills: the level, quality, and/or degree of dyadic and groups interaction skills.

    a. dyadic interaction skills: abilities in relationships to peers, subordinates, and authority figures; demonstrating trust, respect, and warmth; perceiving and responding to needs and feelings of others; engaging in and sustaining interdependent relationships; communicating feelings.

    b. group interaction skills: abilities in performing tasks in the presence of others; sharing tasks with others; cooperating and competing with others; fulfilling a variety of group membership roles; exercising leadership skills; perceiving and responding to needs of group members.

33. Splinting: the provision of dynamic and/or static splints for the purpose of: relieving pain, maintaining joint alignment, protecting joint integrity, improving function, and/or decreasing deformity.

34. Structuring environment: the organization of the client's time, activities, and/or physical environment in order to enhance performance. (see environmental adaptations)

35. Work simplification: the streamlining of the performance of an activity in order to minimize energy out-put.

36. Work skills: skills such as work habits, workmanship, actual skills related to specific job tasks. The skills may refer to the work of the student, home manager, or paid employee. Home manager skills include such skills as cooking, budgeting, shopping, clothing maintenance, house cleaning and maintenance.

APPENDIX VI

Selected Bibliography on Performance Evaluation and the Development of Standards

SELECTED BIBLIOGRAPHY

on
PERFORMANCE EVALUATION
and the
DEVELOPMENT OF STANDARDS

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APPENDIX VII

Packet of Information on Peer Review

PEER REVIEW PACKET

First Edition
August 1975

Section A	Peer Review Articles
Section B	Chart Audit Samples
Section C	Bibliography

Prepared by the:

American Occupational Therapy Association

under the auspices of the
AOTA Continuing Certification Program and the
AOTA - HEW Continuing Competency Contract

NO1-AH-44116

SECTION A

PEER REVIEW ARTICLES

TABLE OF CONTENTS

"A Progress Report on the Medical Audit Study"

"Nursing Audit - Nurses Evaluating Nursing"

"One Step Toward Quality Assurance"

"Peer Review - A Working Experiment"

A Progress Report on The Medical Audit Study

MARTIN L. WALDMAN, MD

A progress report about the Commission on Professional and Hospital Activities' procedure for performing medical audit studies using the Medical Audit Study Worksheet summarizes the problems hospitals and their medical staffs encountered during implementation and offers suggestions for solving these crucial areas of concern.

As the emphasis on medical care evaluation continues, the advent of functioning Professional Standard Review Organizations (PSROs) and the revision of utilization review regulations have made well-defined, explicit medical audit methods indispensable to medical care evaluation. A procedure for performing medical audit studies using the Medical Audit Study Worksheet (MASW) was disseminated in the fall of 1972 by the Commission on Professional and Hospital Activities (CPHA) to help hospital medical staffs solve problems encountered when attempting to implement classical principles of medical audit. Medical staffs encountered difficulty because they did not realize that a systematic medical audit consists of a series of discrete entities called medical audit studies.

A medical audit study includes: 1. A balanced evaluation of the quality of care given to a defined group of patients; 2. an analysis of existing problems; 3. recommendations for solving those problems; and 4. provision for assessing the effectiveness of corrective action. The MASW was designed to help hospital audit committees complete studies in an orderly and effective manner while documenting evidence of medical care evaluation.

An article which described the MASW and its methodology was published in *Hospital Progress* in February, 1973. An actual medical audit study illustrated these 10 steps: 1. Defining the group to be audited; 2. establishing a schedule; 3. adopting standards; 4. retrieving data on performance; 5. comparing performance to standards; 6. classifying problems; 7. recommending corrective action; 8. making provision for monitoring; 9. establishing a date for follow-up; and 10. preparing and transmitting reports.[1] This article is a progress report on the implementation of that earlier medical audit study.

Dr. Waldman is a medical audit consultant, Commission on Professional and Hospital Activities, Ann Arbor, Mich.

Organizing To Audit

Some hospitals need assistance in organizing to perform medical audit studies. They most frequently ask how many committees are required. The number depends on the size of the hospital and the number of active members of the medical staff. Certainly, in a very large and highly departmentalized hospital having many specialty and subspecialty groups, medical audit studies are best performed by the physicians of those departments, divisions, or sections. The audit should be performed by a subgroup (committee) from each section. In a smaller departmentalized hospital, the entire membership of a section should perform the audit. Multidiscipline committees and committees crossing departmental boundaries are useful only for studying topics that apply to patients in several disciplines, e.g., diabetes. The study of specific clinical areas should be assigned to those physicians who usually treat the patients in that specific group.

Audit organization must parallel the chain of command within the medical staff. Audit activity within a clinical department should be under the direction of the chief of that department. Reports should be referred to him so that he can direct the audit activity, assess quality in his area, and assist in initiating corrective action when needed.

Medical staff understanding is necessary for successful medical audit. Before being adopted and published, the standards must be acceptable to the physicians responsible for caring for the patient group being studied. The results of each medical audit also must be published so that the entire medical staff will know that: 1. Audit activities are being carried out; 2. certain standards have been established; 3. excellence has been documented or deficiencies have been noted; 4. appropriate corrective action has been planned; and 5.

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follow-up studies will guarantee that corrective action has had the desired results.

Medical audit is an educational activity which increasingly has become the motivational force behind more interesting and better attended periodic sectional and general medical staff meetings. Medical-administrative functions such as determining whether extra nurses should be assigned to one floor or another or whether beds should be redistributed are better delegated to other committees.

Selecting a Topic

One of the most difficult problems in initiating a workable medical care evaluation system is deciding which patients to audit. Two methods for solving this problem are recommended. First, the hospital should establish a retrospective monitoring technique that simultaneously provides a reasonable assessment of all patient care and information needed to assign priorities for indepth study. The principles of such retrospective monitoring have been described by Vergil Slee, MD.[2] It is now technically possible to monitor the quality of some of the care of *all* the patients *all* of the time. This is done by periodic review of appropriate parameters of data from medical records.

CPHA's tool for comprehensive, continuous monitoring of care, the Quality Assurance Monitor (QAM), was published in June, 1974, as a report book to be completed by the hospital's health record analyst. It includes norms reflecting actual performance with respect to the monitor parameters in a sample set of hospitals participating in the Professional Activity Study (PAS) and urges that individual hospital medical staffs go one step further and establish their own standards. The performance data for all these parameters (353) is retrieved by the health record analyst (HRA) who compares the performance and the standards. Deviations should elicit further examination and, if deemed to reflect a problem (deficiency), an indepth medical audit study. QAM has been computerized (QAM-2) and is available to PAS hospitals.

Second, the medical care evaluation plan should establish a systematic series of indepth medical audit studies designed not only to evaluate performance, but to provide for a systematic review and revision of the standards that are used to evaluate care. Medical care changes as knowledge increases. Standards must reflect these changes and must remain current. Therefore, each topic included in the plan should be reviewed at least once every two years. Of course, a major scientific breakthrough should trigger an immediate review.

The systematic series should include these topics: 1. The specific diagnosis or operation groups listed in QAM (which account for approximately 50 per cent of the patient population of the average short-term general hospital), and 2. the hospitalwide and departmental groups in QAM (which provide systematic review of standards and performance with regard to *all* patients). A departmentalized hospital will require a series of approximately 20 to 25 studies each for medicine and surgery and fewer for other departments. Smaller hospitals can achieve the same result by employing clinically oriented subcommittees.

Scheduling a Study

A systematic, orderly, and efficient series of medical audit studies requires forethought and planning. The following should be considered when establishing a schedule that will enable the audit activity to cover a reasonable portion of the hospital's patient load. It is impossible to conduct a medical audit study during one department (or committee) meeting; the study requires at least three meetings and additional work between meetings. Furthermore, an integrated plan will allow for several simultaneous medical audit studies. **Figure 1** demonstrates how the agendas of a series of monthly meetings can be arranged to "stage" a series of medical audit studies, each on its own schedule.

According to this schedule, the medical audit committee which meets monthly would schedule a medical audit study on a topic as follows:

1. January meeting—select topic (preplanned or triggered by monitor), define group, establish schedule, assign someone to draft standards.
2. Between meetings—draft standards and distribute to committee.
3. February meeting—adopt standards.
4. Between meetings—retrieval of data by HRA.
5. March meeting—compare performance to standards and decide if deficiencies exist. It possible, determine class and level of problem, recommend action objectives, review parameters to be monitored, establish follow-up date, and instruct HRA about preparation of summary to be completed and transmitted. If further information is needed, then
6. Between meetings—collect further information.
7. April meeting—complete the study.

Using this schedule, the agenda of the April meeting would resemble this sample:

Medical Audit Committee
April Meeting Agenda

1. Select and define group for audit D
   Set up schedule for audit D
2. Review and adopt standards for audit C

3. Review data on performance for audit B
   Do problems exist? If so, what type?
   Objectives for action—audit B
   Complete audit B
4. Was audit A completed? If not, complete audit A.

If the audit committee met weekly, each of the committee meeting stages of one audit could be the *only* agenda item. Either approach accomplishes completing one audit a month. Following such a schedule will enable the medical staff to conduct a systematic review that more than meets the requirements for medical care evaluation studies established by accreditation and governmental agencies.

Establishing Standards

Each audit study group must have a set of "pattern standards" that define the desired (optimal achieveable) care. A pattern standard is a statistic, usually expressed as a percentage, which specifies how often an observable objective feature of medical care (called the "parameter") can be expected to be present when the care given to a defined group of patients is excellent. In addition, each pattern standard should include allowable exceptions, i.e., acceptable reasons for breaking the rule. Thus an accounting is made of every patient's care—whether it meets either the standard or the exception—and deviant cases are identified.

The HRA must help devise the standards because only then will he understand their intent and be able to guarantee that the medical staff includes only objective questions that can be answered from data available in the medical record. The instructions for data retrieval must include how to determine which cases should be brought to the physicians' attention. One technique is to assign a screening percentage to each parameter (100 per cent or zero per cent). Either percentage requires that the parameter be sought after on every patient's chart. If a 100 per cent parameter is missing, or if a zero per cent parameter is present, the physicians should be notified. These screening percentages do not necessarily reflect a standard of optimally achievable care; they are only a technique for informing the HRA which cases require peer review.

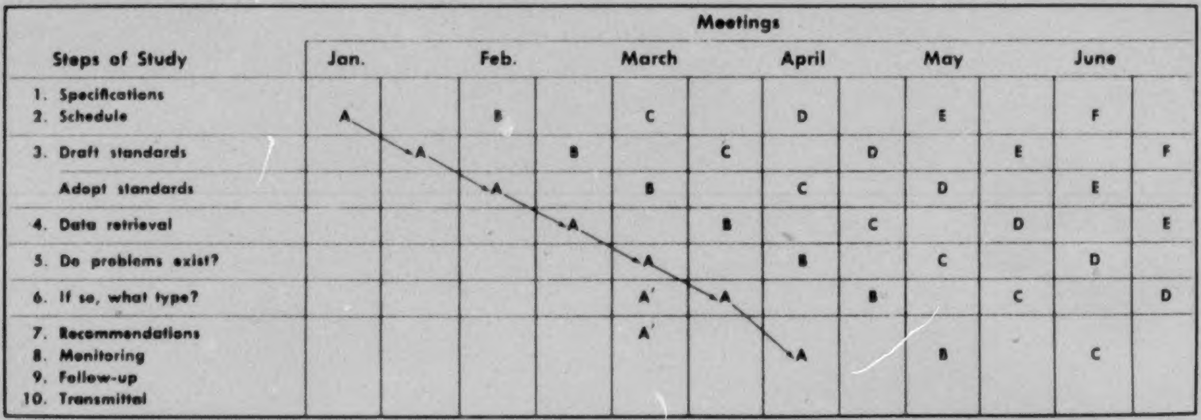
An alternative method is to write self-explanatory standards. For example, a standard for an appendectomy audit could be written as follows:

Justification for surgery—100 per cent—which must be
1. Diseased tissue (85-90 per cent), or
2. Evidence of abdominal pain, nausea, or vomiting, and an elevated white count (all others).

Choosing Parameters

More information about the kinds of parameters that

FIGURE 1: Staging of Medical Audit Studies



Steps of Study	Meetings											
	Jan.		Feb.		March		April		May		June	
1. Specifications 2. Schedule	A		B		C		D		E		F	
3. Draft standards		A		B		C		D		E		F
Adopt standards			A		B		C		D		E	
4. Data retrieval				A		B		C		D		E
5. Do problems exist?					A		B		C		D	
6. If so, what type?					A′	A		B		C		D
7. Recommendations 8. Monitoring 9. Follow-up 10. Transmittal					A′		A		B		C	

KEY:
A = Audit schedule of topic A
A′ = Alternate schedule, illustrated for topic A

should be used in evaluating medical care appears continually. First, there should be parameters of "justification," i.e., those that: 1. Validate the diagnosis (for studies defined by diagnosis); 2. justify the admission to the particular type of facility; and 3. indicate the need for surgery or other modes of investigation or therapy that are costly or risky to the patient.

Evaluating the outcome of hospital care must include an examination of mortality, both the rate and the individual records of the deceased. Complications of the disease itself and of the hospitalization also should be examined. Some of the complications of the disease itself would be justification for admission to the hospital. Other complications should be listed to enable the medical staff to discover whether avoidable complications are occurring and whether complications that are not completely avoidable are being minimized sufficiently.

Evaluating the outcome of care also requires evaluating the patient's health status at the time of discharge in order to in turn determine if he was discharged at the appropriate point in recovery. In addition, parameters should examine plans for the continuation of care after discharge and indicate whether the patient received adequate discharge instructions.

The concept of examining the discharge status of patients is included in the model screening criteria produced by the American Medical Association's PSRO project and recommended by the Joint Commission on Accreditation of Hospitals. An examination shows that these discharge status criteria refer to the degree of return to normal physiologic function and achievement of goals of hospitalization. For such data to be routinely abstracted from medical records, precise instructions must be provided. **Figure 2** is a set of discharge status data. All items refer to information on the patient's medical record and to the day of or day before discharge (unless otherwise noted). These items are not to be interpreted as criteria, all of which must be met by each patient; they are only a means of describing the patient's health status. They are preliminary ideas that will have to be tested and probably revised to meet local needs.

Furthermore, each medical audit study also should include parameters necessary to identify those diagnostic tests that are used to: 1. Screen patients to discover heretofore unsuspected problems (e.g., blood pressure, urinalysis), and 2. establish the diagnosis, monitor the patient's progress, or indicate the need for various types of therapy. Critical management of patients should be evaluated by including those things done to: 1. Treat the disease being evaluated; 2. pre-

FIGURE 2: Data Set on Discharge Status

(All are questions to be answered yes or no.)

1. Afebrile for 24 hours?

   Are all temperatures (taken and recorded on the day of discharge or the day before) below 100° F?

2. Normotensive?

   Are all blood pressures between 140/90 and 90/60?

3. Not anemic?

   Do all hemoglobins (hematocrits) have a value of 10 (30) or above?

4. Normal gastrointestinal function?

   Is there a nursing note or progress note indicating that the patient was tolerating an oral diet and had a formed bowel movement?

5. Normal urinary function?

   Do the nursing notes or progress notes indicate that the patient was voiding spontaneously (or his indwelling catheter was functioning) and that the last urinalysis indicated there was no acetone in the urine? (This does not imply requiring a discharge urinalysis and is the exception to the rule concerning the last two days of hospitalization.)

6. Ambulation or performance of activities of daily living noted?

   Is there a statement in the nursing notes or progress notes relating to the patient's ability to ambulate or take care of himself?

7. Conscious?

   Is there a note in the nursing or progress notes stating that the patient is oriented as to time and place and his sensorium is clear?

8. Lack of patient complaint?

   Are there notes (nursing or progress) that indicate that the patient was questioned and responded negatively to: 1. the presence of pain; 2. dizziness; 3. nausea; 4. disturbed sight or hearing; 5. difficulty or pain on urination; and 6. difficulty in breathing?

9. Progress satisfactory?

   Are there notes indicating satisfactory progress toward recovery? For surgical patients, this requires the presence of a note stating that the wound is healing satisfactorily. For delivery patients, a note stating that the vaginal discharge after delivery had diminished satisfactorily is required. For other patients, notes stating that the recovery from disease has progressed to the point where they may be safely discharged are imperative.

10. Patient given discharge instructions?

    Do the nursing or progress notes state that the patient has been given discharge instructions?

vent complications; and 3. treat complications that do occur.

Avoiding Pitfalls

When establishing standards, the first pitfall is the tendency, especially when first attempting a medical audit study, to include too many parameters. The beginner is apt either to try to reproduce the textbook logic tree for a differential diagnosis or to combine research with quality evaluation. This results in excessive demand on physician time for selecting parameters and reviewing retrieved data and on nonphysician time for data retrieval and display. The list of parameters should be restricted to those relevant to the quality of care. A parameter is relevant only if corrective action will be recommended when performance is inferior.

The second major pitfall is excessive concern with details. Medical care evaluation is designed to provide sufficient feedback to permit rational decisions for needed changes. Documenting details of individual errors serves the function of accountability, but does not necessarily produce change. To be effective, corrective action *must affect the habits, practices, and systematic functioning of the hospital and its medical staff.*

A third pitfall is the failure to use parameters that are objective, observable features of care. Using subjective items that require expert medical judgment forces physicians to read every medical record themselves—a waste of valuable physician time.

Standards must be internalized. Standards may be suggested by individuals or committees of the medical staff, but effective audits require that they be acceptable to the physicans who treat the type of patient under review. If these physicians accept the standards and know that their colleagues also accept them, they will tend to change their practices to meet the standards.

Data Retrieval

The standards adopted by the medical staff are a prescription for the retrieval of information describing the pattern of care given to patients in the hospital. The data may be retrieved from computer-prepared reports of information routinely abstracted from medical records or from displays of data specifically abstracted for each study. In either case, some effort should be made to validate the abstracted data. Certainly, when the data seems to indicate a deficiency, the HRA should check at least a sample of the records to be certain that no abstracting error has been made. This verification of the data should be documented in a memorandum to the physicians performing the audit.

In time, the HRA will become familiar with the medical staff's reasoning and will be able to anticipate what additional data (summary of specific cases, descriptions of where problems are clustered, etc.) the physicians will need in order to analyze problems and make recommendations.

Peer Review

The conduct of medical audit studies can be considered to be peer review in one of its purest forms. Physicians establish the standards for medical care, and physicians evaluate its results. But efficient peer review also requires the input of the HRA, a nonphysician trained in the techniques of evaluating care and retrieving and displaying performance data. In addition, through the use of criteria established by the medical staff, the HRA can perform the screening needed to select those records that do require indepth evaluation by peers.

Eliciting Action

Once problems have been discovered and analyzed, the greatest challenge facing the medical staff is how to elicit action to change behavior. Mere reporting of poor performance to chiefs of staff and to the board is not likely to change behavior.

Effective methods for changing the behavior of any group (or individual) require two actions: 1. Precisely identifying what needs to be changed, and 2. motivating the appropriate persons. Effective action should produce a change in habits. In contrast, requiring an apology for poor performance results only in a defensive attitude and often serves to strengthen previous convictions and behavior.

Identifying what needs to be changed and providing the information and skills needed to improve care is a function of the hospital's continuing medical education program. Motivation is best achieved through nonthreatening peer pressure. Physicians who are not performing satisfactorily must be made aware of how the remainder of the staff is performing. Of course, peer pressure only helps cure those problems directly related to physician behavior.

Many, and probably the majority of hospital medical care problems, are not attributable to physician behavior, but to improper functioning of some other area of the hospital. Solutions to such problems are varied and often unique. Obtaining additional resources and reallocating current ones to solve problems caused by inadequate tools, equipment, staff assignment, etc., may be necessary. Action is a function of the degree of problem solution motivation, which is a cooperative arrangement between the medical staff and the administrator. The latter must be confident that recommended changes are not capricious, are based on actual facts discovered in the medical audit, and will result in better patient care.

At times the motivation may have to originate with the governing body of the hospital. If a change is necessary, if there is good and logical reason for it, the administrator and the governing body should be easily convinced. But, again, the pressure exerted must be nonthreatening. Mere confrontation is of no value.

Who has the responsibility for taking action in the hospital? A medical audit study is a fact-finding and action-recommending procedure that takes place within the medical staff organization at the appropriate level. As part of an audit, the medical staff may recommend specific action or may leave that decision to the individual responsible for solving the problem. If education is the appropriate action, then the director of education should be the one to take the action and document it. If solving a problem requires a change in the physical plant of the hospital, then the administrator would be involved. If action is required within the nursing service, then the director of nursing is the logical person to contact. Furthermore, certain types of problems may require action by the governing body itself.

Documenting Quality Control

For each medical audit study a formal study file is required to collect the documentation. The MASW is the basic documentation of the fact-finding and recommendation function of a medical audit. But it alone will not suffice. A summary should be written to be transmitted to the governing body (or PSRO when this becomes a requirement) and for publication to be read by the entire medical staff. This summary would include statements concerning: 1. Why the study was performed; 2. who made up the patient group; 3. in general, what patterns of care were found and how they compared to the standards; 4. specific recommendations for action; and 5. when follow-up is planned.

Reports by the HRA of problems that were uncovered during data retrieval and details about specific cases that have been brought to the attention of the audit committee should be kept in the file. The file also should contain reports from the various individuals required to take the recommended action. The reports should describe what the action is and when it was (will be) taken. The complete file should include follow-up studies demonstrating that the desired result of action (observable changes toward meeting the requirements defined by the standards) have actually been achieved in a timely and effective manner. This documentation might include memoranda documenting receipt of the request for action, announcements of programs that will be (or have been) carried out, and other reports and memoranda that may be applicable.

Conclusion

During the two years since the CPHA devised a procedure for medical audit studies using the MASW, there has been a great deal of progress in efforts to control the quality of care. Improvements have been made in the organization needed for efficient auditing. The QAM has been introduced to assist hospitals in monitoring the care of all patients and in selecting topics for audit. Techniques for staging and scheduling studies have been developed. The selection and writing of standards has been refined; more attention is being paid to the necessity for eliciting action; and the methods of documenting quality control have been made more explicit. Thus the road to successful quality assurance in the hospital is better defined today than ever before, but much still needs to be done. ★

FOOTNOTES

1. See Martin L. Waldman, "The Medical Audit Study—A Tool for Quality Control," *Hospital Progress*, February, 1973, pp. 82-88. The MASW worksheet discussed and reproduced in this article was revised in April, 1974, and simplified to demonstrate its congruence with the method for patient care evaluation outlined by the Joint Commission on Accreditation of Hospitals. In November, 1974, the CPHA medical audit study method received the official recognition of the Department of Health, Education, and Welfare's Bureau of Quality Assurance (PSRO Transmittal No. 11) for meeting the retrospective medical care evaluation study requirements for PSRO.

   Since publication of the article, CPHA has distributed over 44,000 reprints and requests for over 72,000 copies of the MASW, which has been the mainstay of an intense educational effort by CPHA. Approximately 2,242 classroom hours of medical audit methodology have been taught in 148 formal CPHA education sessions since September, 1972. These sessions were attended by 8,570 participants from the health care field. In addition, since 1973, hospitals and health-related organizations have used material prepared by CPHA to schedule over 100 slide presentations and over 400 videotape showings.

   In March, 1975, the worksheet and procedure were revised in response to feedback from hospitals and groups that had employed them, as well as from other organizations involved in medical care evaluation. Copies may be obtained from CPHA, 1968 Green Rd., Ann Arbor, Mich. 48105.

2. Vergil N. Slee, "PSRO and the Hospital's Quality Control," *Annals of Internal Medicine*, July, 1974, pp. 97-106.

Nursing Audit – Nurses Evaluating Nursing

Auditing a patient's chart not only indicates what care ought to be included, but also assures that the care which was given is documented.

CHARLENE F. RUBIN / LEENA A. RINALDI / RUTH R. DIETZ

A nursing audit need not be drudgery. In our case, it led an entire nursing staff to appreciate what good sources of information they are about patient care and how much they can contribute to improve care. At St. Luke's Hospital Center in New York City, the decision to audit has lead to a variety of ways to pursue better care.

The original decision to audit was inspired by a lecture by the dynamic and notable author and lecturer Helen Dunn, which the associate director of nursing service attended. With the help of an enthusiastic cochairman she recruited and chaired a committee to plan the quest for a meaningful audit.

Although we improvised, many of Ms. Dunn's concepts were, in fact, the reason for our success, and chief among these were enthusiastic leadership and stability of membership on the audit committees. To achieve stability, we recruited members for the central committee from positions that have demonstrated low turnover: as a result, the eight-member committee is made up chiefly of nursing service administrators, supervisors, and inservice instructors.

At the first meeting of the Central Nursing Audit Committee, members explored and criticized literature on the subject and became acquainted with the philosophy, standards, and format of the nursing audit as presented by Helen Dunn.[1]

The committee decided two core groups were needed. The committee would continue as the Central Nursing Audit Committee and there would also be a Departmental Nursing Audit Committee. Both have officers and meet monthly from September through June and at other times as the chairmen designate. The central committee sets policies, procedures, and forms and also evaluates the results of departmental audits.

The Departmental Nursing Audit Committee consists of supervisors or head nurses from eight departments—surgery, pediatrics, orthopedics, medicine, psychiatry, obstetrics-gynecology, urology, and eye, ear, nose and throat. Each member selects staff members on a rotating basis from her service to audit charts. The departmental committee member collects data from the auditors and presents them at monthly meetings of the Departmental Nursing Audit Committee. This committee then reports to the Central Nursing Audit Committee.

Our chart audit began with a few selected "dead" charts of discharged patients and has progressed to "live" charts of current patients. The purpose was to evaluate the quality of patient care as seen through the nursing record. Now, on a rotation basis, head nurses and staff nurses and clerical assistants, using three different forms, check the charts. The clerical assistant checks for proper charting procedures, graphics and stamping, using the form "Mechanics of Chart," which is reproduced on p. 918.

Nurses use the form "Nurses' Notes," also reproduced (on p. 919) looking for evidence of minimum requirements which are listed on the form. They then write their conclusions on a summary form.

Today, auditors on the major services—medicine, surgery, and obstetrics-gynecology—check 10 charts a month and those on the other services check approximately 5 charts a month. An average chart takes a half hour to audit, so employees on the 3 major services spend approximately 15 hours a month on chart auditing; those on the other 5 services spend about 12½ hours a month. This time varies, of course, depending on staffing patterns, other projects, workshops, and so forth.

As the program of auditing began, the departmental committee made several recommendations with which the central committee concurred:

1. Head nurses should review some charts daily with definite goals

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[1] DUNN, H. W., AND MORGAN, E. M. *The Nursing Audit.* (League exchange No. 84) New York, National League for Nursing, 1968.

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The supervisors make grand rounds of a different unit each week to evaluate the nursing care given and the organization of the unit. Recommendations are made at a session following rounds.

in mind. Priorities on a given day may be graphics, preoperative charting, every-four-hour charting for postoperative patients, nursing observations and interventions, or patient teaching and disposition.

2. Head nurses adept at auditing should teach other head nurses their auditing skills.

3. Auditing should be part of orientation for new nurses, and the evening and night staff should assist with auditing.

Other recommendations covered periodic meetings, written communication, and the like.

Committee members were instructed on proper methods for documenting data, and many of the early work sessions were committed to this end.

A summary form entitled "Mechanics and Nurses Notes" (see p. 921), was created for use after each departmental representative presents her findings and recommendations at monthly meetings.

Later, a section for actions was included in order to emphasize that auditing is an active process and that just making recommendations is not enough; they must be acted upon.

For example, some resultant activities reported were: "All new staff are oriented to the philosophy of nursing audit and correct charting procedure. They are encouraged to participate in actual auditing." "The principles of nursing audit were presented to all levels of our nursing staff. Audit is active continuing education." "Notices of specific problems have been placed in our weekly 'Nursing Service Newsletter'."

An Enormous Step

The transition from auditing dead records came when the supervisor in the gynecology department said that nurses in her units wanted to do live audits. The chairman of the departmental committee and this

"The essence of the practice of nursing should be clearly evident in the nurses' notes for all to see and research."

supervisor then went to one of the gynecology units and started the first audit of live charts. Compilations of obstetric and gynecologic findings were all under one section on the outstanding problems report (see January 1971 Monthly Report on p. 921). However, the head nurse on a gynecology unit thought her problems were different and she requested that her unit be identified separately.

The ability to look at one's attributes and deficiencies is an enormous step toward maturity, and we concluded that it was to the credit of the nursing audit that nurses on the units were asking for a change from anonymity, for it meant trust.

As yet, we had not arrived at the final evaluation for planned nursing care. "Nurses' Notes" satisfied minimal nursing service policy requirements, but we were striving for more. Our goal was the implementation of planned individual patient care. Nursing care plans and nurses' notes, we believed, must reflect this.

After having undergone this arduous process, we highly recommend that all nurse educators, supervisors, and administrators share this evaluation process, for an amazing thing takes place. Participants realize that planned patient care requires efforts that are tedious, disciplined, intellectual, and time consuming.

When doing this evaluation one, in effect, relives the planning process done by nurses caring for the patients. For example; the co-chairman reviewed the entire chart and care plan of a 55-year-old woman with a history of difficulty in walking and weight loss. Nurses' notes pointed out the weakness in the patient's legs, lack of appetite, and her use of a walker. However, the nurses' notes did not mention occupational therapy's role or consultation with the dietitian and a care plan should have evolved accordingly.

During evaluation of this chart the co-chairman had an almost irresistible urge to ask the head nurse for particulars about the patient—this often is a sign of inadequacies in nurses' notes. Nurses frequently do not realize that they have valuable information about patients; instead of sharing this information, they often take it home with them.

The co-chairman took her questions to the head nurse and learned that the dietitian had, in fact, seen the patient and that members of the nursing staff were actively involved with efforts to increase the patient's food intake. What the staff had failed to do was document their efforts. During postevaluation conference, the head nurse saw this immediately but, would this have happened if the co-chairman had just told her to, "Write better nurses' notes"?

In spite of Marshall McLuhan's

MECHANICS OF CHART

	Yes	No	Does not Apply
1. All record sheets and notes are properly identified.			
a. Headings filled out completely and legibly.			
b. Stamped with addressograph.			
c. Correct dates entered.			
d. Signature of recorder included after each note.			
e. All notes preceded by correct date and time, indicating A.M. and P.M.			
f. Notes appear in correct sequence. No blank spaces left unless lines drawn to prevent illegal entries.			
g. Recordings are legible, and in ink or ball pen.			
h. At least one daily nurse's note is written.			
2. T.P.R. and Graphic Record completed.			
a. Blanks filled in for calendar dates, and for hospital and postoperative days.			
b. Graphs of Temps and Pulse clear and complete.			
c. Respirations, B.P., Wt., stools, and diet recorded properly.			
d. Fluid intake and output record complete on TPR sheet.			
e. All tests and treatments recorded properly.			
3. Complete Admission note appears on Admission-Transfer-and-Discharge Data Sheet.			
4. Complete Discharge note appears on nurses notes and Admission-Transfer-and-Discharge Data Sheet completed.			
5 Include transfer note, if indicated, on Admission-Transfer-and-Discharge Data Sheet.			
6. All identifying information appears on authorization permits including signature of witnesses.			

This chart should be referred to C. N. A. Committee.

Reason for this referral ______________ ______________

Signature Auditor

Please use reverse side (or above spaces) for comments.

A clerical assistant uses this form for her part of an audit of a patient's chart.

theories, our culture values the written word and this is nowhere more evident than in the professions, where prestige is often accorded on the basis of written documentation. The essence of the practice of nursing should be clearly evident in the nurses' notes for all to see and research.

Traditionally, a nurse's feet have often been more valued than her mind. In addition, having been trained in an autocratic type of program to believe that she must be infallible, she often avoids placing herself in a situation where her actions and thoughts can be criticized, such as might occur if these were documented. Whatever the reason, there is a paucity of written evidence of nurses' daily practice.

We decided that part of our problem was an inadequate Kardex. Many nurses said that the Kardex was not large enough to fulfill our expectations and was, therefore, a major barrier. Along with this, the format was considered not suitable. A pilot study got underway, with a Kardex Committee comprised of a cross-section of professional nurses to recommend and institute revisions. A new Kardex emerged, larger and better. The illustration on p. 920 shows the format.

Although the nursing audit was working well and tools for it had been prepared, the major area which still needed improvement was nursing care plans. Despite the attempts of continuing education staff at St. Luke's workshops, and various authoritarian measures, staff were not using care plans effectively. Nursing service administrators and continuing education instructors, therefore, reviewed nursing care plans on all units. They identified the individuals who demonstrated expertise in the planning of patient care and asked these nurses to form a Nursing Audit Subcommittee on Nursing Care Plans. The task of this subcommittee was to assist their colleagues in devising nursing care plans.

This is one of two forms a nurse uses as she audits patients' charts.

NURSES' NOTES

	Yes	No	Does not apply
A. Condition of patient			
1. Changes, pertinent signs, symptoms, or actions are included.	____	____	____
2. At least one note is written daily.	____	____	____
3. If seriously ill or postoperative, at least one note is written every four hours.	____	____	____
4. Patients' physical abilities and limitations.	____	____	____
B. Medications			
1. Reason for administering p.r.n. or S.O.S. medication is noted.	____	____	____
2. Results of p.r.n. and S.O.S. medication are noted.	____	____	____
3. Explanatory note is recorded when any standing medication has not been administered.	____	____	____
4. A note is recorded when intravenous solution containing medication is not completed. Amount absorbed is included.	____	____	____
C. Drainage from any orifice—Note includes:			
1. Source	____	____	____
2. Type	____	____	____
3. Consistency	____	____	____
4. Odor	____	____	____
5. Color	____	____	____
D. Special feeding—Note includes:			
1. Type	____	____	____
2. Ability to tolerate	____	____	____
3. Notation of time given	____	____	____
4. Source	____	____	____
5. Type	____	____	____
6. Consistency	____	____	____
7. Odor	____	____	____
8. Color	____	____	____
E. Suction or siphon drainage—Note includes:			
1. Type	____	____	____
2. Description	____	____	____
3. Amount of drainage	____	____	____
F. Use of oxygen—Note includes:			
1. Method administration	____	____	____
2. Duration	____	____	____
3. Liter flow	____	____	____
G. Treatments			
1. When nurse assists the doctor, a note is written.	____	____	____
2. When an untoward reaction occurs, a descriptive note is written.	____	____	____
3. When the nurse performs a treatment, the note includes:			
a. Time	____	____	____
b. Type	____	____	____
c. Results	____	____	____
d. Reactions	____	____	____
H. Blood transfusion			
1. Rectal temperature, pulse, and respiration have been taken.			
a. immediately prior to administration of transfusion.	____	____	____
b. every half-hour during the course of the transfusion.	____	____	____
c. one-half hour after completion.	____	____	____
2. Any unusual reactions have been noted.	____	____	____
I. Surgical procedures			
1. Preoperative care			
a. All procedures as ordered have been completed.	____	____	____
b. Patient's voicing has been recorded.	____	____	____
c. Jewelry, prostheses, and other objects have been removed.	____	____	____
d. Valuables removed for safe-keeping are recorded.	____	____	____
2. Postoperative care			
a. Reaction from anesthesia	____	____	____
b. Vital signs	____	____	____
c. Staining	____	____	____
d. Voiding	____	____	____
e. Fluid or food tolerance	____	____	____
J. Personal property			
1. Disposition of clothing and valuables is made in the admission notes.	____	____	____
2. Disposition of valuables key is recorded.	____	____	____
K. Discharge			
1. This last entry includes:			
a. Date	____	____	____
b. Time	____	____	____
c. Name of institution or Home Care (where applicable).	____	____	____
2. If after 11:00 A.M., reason for late discharge is included.	____	____	____
L. Ceased breathing			
1. Last observations	____	____	____
2. Date	____	____	____
3. Time pronounced dead	____	____	____
4. Name of certifying physician is included	____	____	____

This chart should be referred to C. N. A. Committee.

Reason for this referral: ....

Signature: .... ***Auditor:*** ....

The nursing care plan should become a permanent part of each patient's record.

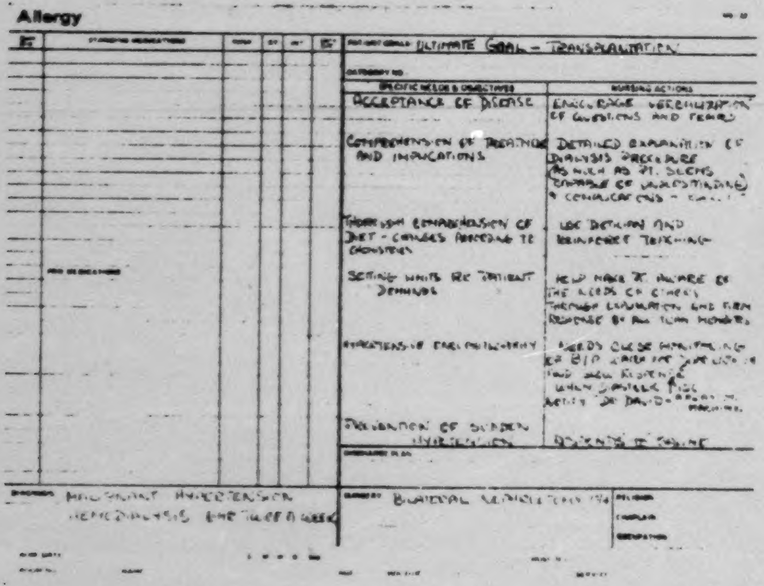
Subcommittee members decided their ultimate objective was to set criteria for evaluating nursing care plans and to act as consultants to the various units in the design of nursing care plans that were practical, that is, pertinent, concise, and realistic in design.

Their recommendations included the following:

- Care plans should determine priorities for patient care based on the nurse's synthesis of her knowledge and observations of patient response.
- These plans should reflect a concept of planned deliberative nursing care into their mode of operation.
- Subcommittee members should give this project their complete attention for maximum results.
- The efforts of this subcommittee should be endorsed and their recommendations followed by all responsible nursing personnel.
- The nursing care plan should become a permanent part of each patient's record, to serve as a ready reference.
- Routine admissions which do not warrant nursing intervention should be identified as "self-directed care." Nurses should refrain from preparing care plans on these patients, who would otherwise have plans just for the sake of complying with expectations.

In order to share their ideas with staff and to promote participation, all committee members took part in a panel discussion on nursing care plans, which was video taped and presented to all shifts. The head nurses attended the original live presentation.

During discussion nurses agreed that nursing care plans do result in better care, better continuity of care, and do save time in orienting new staff members to their patients.



Allergy

ULTIMATE GOAL – TRANSPLANTATION

ACCEPTANCE OF DISEASE	ENCOURAGE VERBALIZATION OF QUESTIONS AND FEARS
COMPREHENSION OF TREATMENT AND IMPLICATIONS	DETAILED EXPLANATION OF DIALYSIS PROCEDURE (AS MUCH AS PT. SEEMS CAPABLE OF UNDERSTANDING) & COMPLICATIONS – [illegible]
THOROUGH COMPREHENSION OF DIET – CHANGES ACCORDING TO CHEMISTRIES	USE DIETICIAN AND REINFORCE TEACHING
SETTING LIMITS RE PATIENT DEMANDS	HELP MAKE PT. AWARE OF THE NEEDS OF OTHERS THROUGH EXPLANATION AND FIRM RESPONSE BY ALL TEAM MEMBERS
HYPERTENSIVE [illegible]	NEEDS CLOSE MONITORING OF B/P [illegible]
PREVENTION OF SUDDEN HYPERTENSION	[illegible]

MALIGNANT HYPERTENSION
HEMODIALYSIS 3 TIMES A WEEK

BILATERAL NEPHRECTOMY [illegible]

The nursing care plan of the patient on dialysis is written on a new enlarged Kardex, which is 8½-by-11 inches. Both sides are alike.

Panelists suggested that sample plans from each specialty area could be filed and used as guidelines by all units as needed. They recommended that plans be tailored to the needs of each patient, revised with the changing needs of the patient and not be regarded as just a static procedure. There also was discussion of initial patient interviews and discharge summaries.

Unit Evaluation

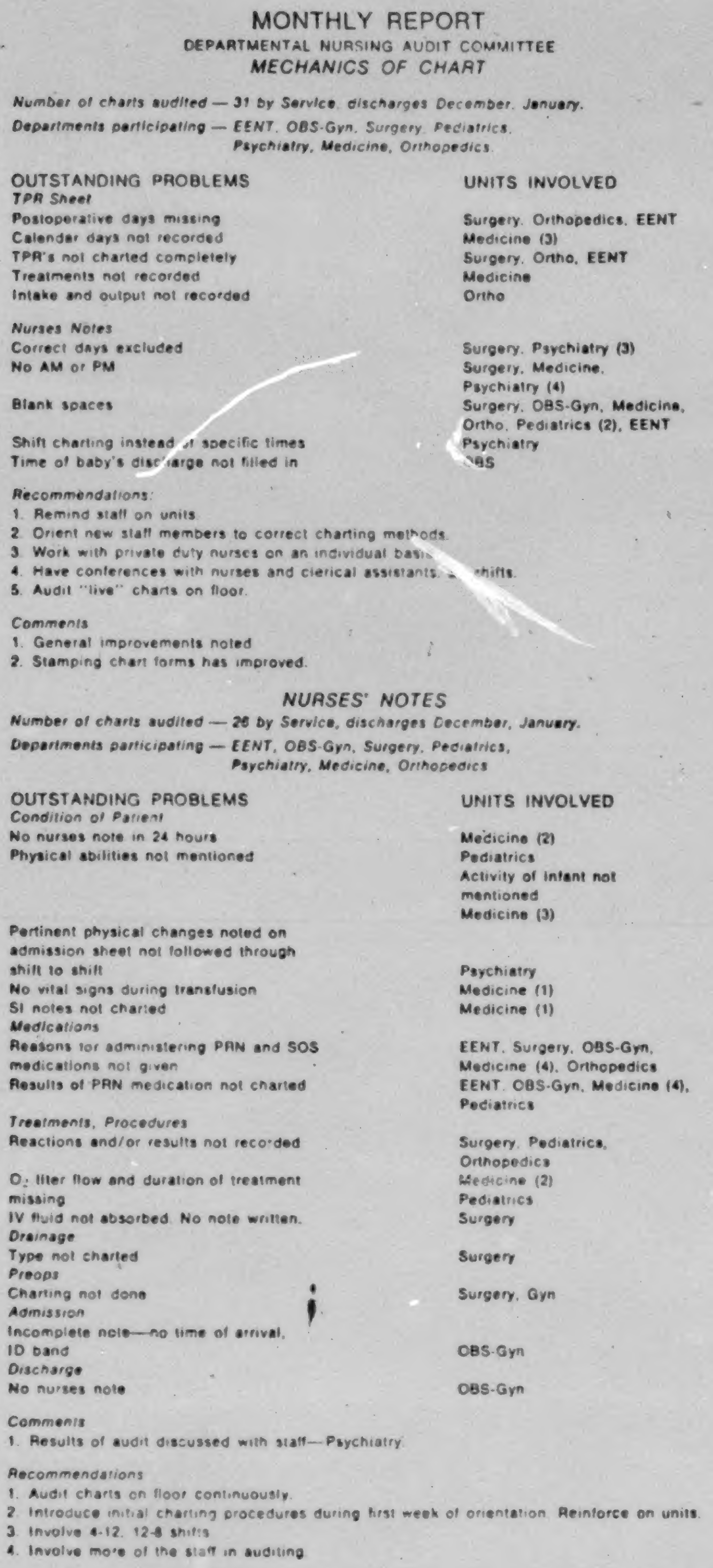
Since we consider nothing as extraneous in auditing nursing care, we then ventured into nursing unit evaluation, with patient questionnaires, incident reports, and supervisors' grand rounds.

PATIENT QUESTIONNAIRES Upon discharge from the hospital, each patient is given a questionnaire to evaluate his care. He may submit the questionnaire either prior to discharge or send it by mail later. Responses are reviewed and tabulated by the Public Relations Department and then sent to the departments concerned.

In the nursing service department, the director and associate director read all returned questionnairs. Comments, requests for investigation, and notes of appreciation are written where warranted and then forwarded to supervisors, who, in turn, share this information with staff members.

The associate director keeps all monthly summaries of patient questionnaires to compare rating results. Also, she pursues the investigation of any questions the patient evaluations raise.

INCIDENT REPORTS The Central Nursing Audit Committee along with the continuing education staff studied a compilation of medication errors made since 1969 to determine learning needs and devise preventative measures. This analysis included all tabulations, units, shifts, dates, classifications, and individuals involved. Findings were shared with nursing leaders, and the continuing education staff members followed



MONTHLY REPORT
DEPARTMENTAL NURSING AUDIT COMMITTEE
MECHANICS OF CHART

Number of charts audited — 31 by Service, discharges December, January.

Departments participating — EENT, OBS-Gyn, Surgery, Pediatrics, Psychiatry, Medicine, Orthopedics.

OUTSTANDING PROBLEMS	UNITS INVOLVED
TPR Sheet	
Postoperative days missing	Surgery, Orthopedics, EENT
Calendar days not recorded	Medicine (3)
TPR's not charted completely	Surgery, Ortho, EENT
Treatments not recorded	Medicine
Intake and output not recorded	Ortho
Nurses Notes	
Correct days excluded	Surgery, Psychiatry (3)
No AM or PM	Surgery, Medicine, Psychiatry (4)
Blank spaces	Surgery, OBS-Gyn, Medicine, Ortho, Pediatrics (2), EENT
Shift charting instead of specific times	Psychiatry
Time of baby's discharge not filled in	OBS

Recommendations:

1. Remind staff on units.
2. Orient new staff members to correct charting methods.
3. Work with private duty nurses on an individual basis.
4. Have conferences with nurses and clerical assistants on shifts.
5. Audit "live" charts on floor.

Comments

1. General improvements noted.
2. Stamping chart forms has improved.

NURSES' NOTES

Number of charts audited — 26 by Service, discharges December, January.

Departments participating — EENT, OBS-Gyn, Surgery, Pediatrics, Psychiatry, Medicine, Orthopedics

OUTSTANDING PROBLEMS	UNITS INVOLVED
Condition of Patient	
No nurses note in 24 hours	Medicine (2)
Physical abilities not mentioned	Pediatrics Activity of infant not mentioned Medicine (3)
Pertinent physical changes noted on admission sheet not followed through shift to shift	Psychiatry
No vital signs during transfusion	Medicine (1)
SI notes not charted	Medicine (1)
Medications	
Reasons for administering PRN and SOS medications not given	EENT, Surgery, OBS-Gyn, Medicine (4), Orthopedics
Results of PRN medication not charted	EENT, OBS-Gyn, Medicine (4), Pediatrics
Treatments, Procedures	
Reactions and/or results not recorded	Surgery, Pediatrics, Orthopedics
O_2 liter flow and duration of treatment missing	Medicine (2) Pediatrics
IV fluid not absorbed. No note written.	Surgery
Drainage	
Type not charted	Surgery
Preops	
Charting not done	Surgery, Gyn
Admission	
Incomplete note—no time of arrival, ID band	OBS-Gyn
Discharge	
No nurses note	OBS-Gyn

Comments

1. Results of audit discussed with staff—Psychiatry.

Recommendations

1. Audit charts on floor continuously.
2. Introduce initial charting procedures during first week of orientation. Reinforce on units.
3. Involve 4-12, 12-8 shifts.
4. Involve more of the staff in auditing.

Each month, when chart audit is over, a committee summarizes the problems, shown on the two forms: "Mechanics of Chart" and "Nurses' Notes."

through on suggested recommendations.

All other incident reports were also reviewed as a means for improving nursing care.

SUPERVISORS' GRAND ROUNDS Each week a different unit is selected in advance for observation. All supervisors, representatives from the continuing education department, and the associate director of nurses visit the unit to evaluate the philosophy, management, and quality of nursing care. Also evaluated are nursing care plans, patient and family teaching, conferences, change-of-shifts reports, nursing rounds, and staff utilization. They also review assignment sheets, cost control measures, and organization of the unit.

Upon completion of each grand round, all supervisors meet for a "postmortum" session, where comments and recommendations are made. A record of these rounds, including the results of postmortum sessions, is kept by the associate director. These rounds also aid the associate director in her evaluation of the responsible supervisor.

Unit evaluation by students and staff nurses is one of the goals we have set for the coming year. We will continue with our previous concerns. The central committee has continued to revise tools for auditing and to strive for further improvement. We attempted to devise a tool for auditing actual patient care, but have not yet agreed on terms.

We have made great strides at St. Luke's Hospital Center providing nurses with many opportunities to improve their skills and encouraging self-evaluation in a supportive climate. As a result, nurses are discovering the joy of giving mature, intelligent patient care of high quality.

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One step toward quality assurance

A fast and simple auditing procedure for inpatients improves patient care at Hinsdale (IL) Sanitarium and Hospital

by Gail Pelley, R.N.

WHEN THE TERM "nursing audit" was first introduced, it brought an automatic response: "What is it, more work?" But, is that really true? Does a nursing audit need to be lengthy and involved? What is our real objective for doing these audits?

Believing that an audit is one way to evaluate adequacy and effectiveness of nursing care, nurses at Hinsdale (IL) Sanitarium and Hospital formed a committee to study the implementation of an auditing program at the hospital. Samples of audit forms were requested from several hospitals. These forms ranged in length from three to seven pages, and an hour was not an unusual amount of time needed to carry out the audit. That perhaps audits do need to be lengthy and involved was a possibility the committee wished to consider. Unable to accept this hypothesis, however, the committee decided to give more study to its reasons for desiring this added task. Our purpose, we decided, was to improve the quality of nursing care given to patients.

Developing the audit

Limiting our purpose in this way enabled us to delete those portions of the audit form dealing with the mechanics of charting. For example, we were not as concerned about whether all of a patient's temperatures were connected by a straight line on the graphic sheet as we were about whether we took a patient's temperature often enough to ensure safe, adequate nursing care. After eliminating the mechanics, we needed to develop a tool that would cover all patient needs as completely as possible. After evaluating these needs, we decided to attempt to adapt the list of 21 problems developed by Abdellah and Levine.* Through consolidation of this list, it was possible to design a tool that could be confined to a one-page form (see the figure on p. 78). An additional form was constructed by listing the following one-word descriptions or short statements of types of specific information to consider under each problem:

1. Hygiene, physical comfort
    - body
    - mouth
    - hair
    - nails
    - shaved
    - pressure areas
    - back care
    - pain
2. Referrals
    - patient teaching
    - rehabilitation
    - admission
    - discharge planning

This second form was needed and used in the beginning of our auditing process but became less and less needed as our staff became more aware of these different problem areas.

Our next decision was to deter-

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*Abdellah, F., and others. *Patient-Centered Approaches to Nursing.* New York City: The Macmillan Co., 1960.

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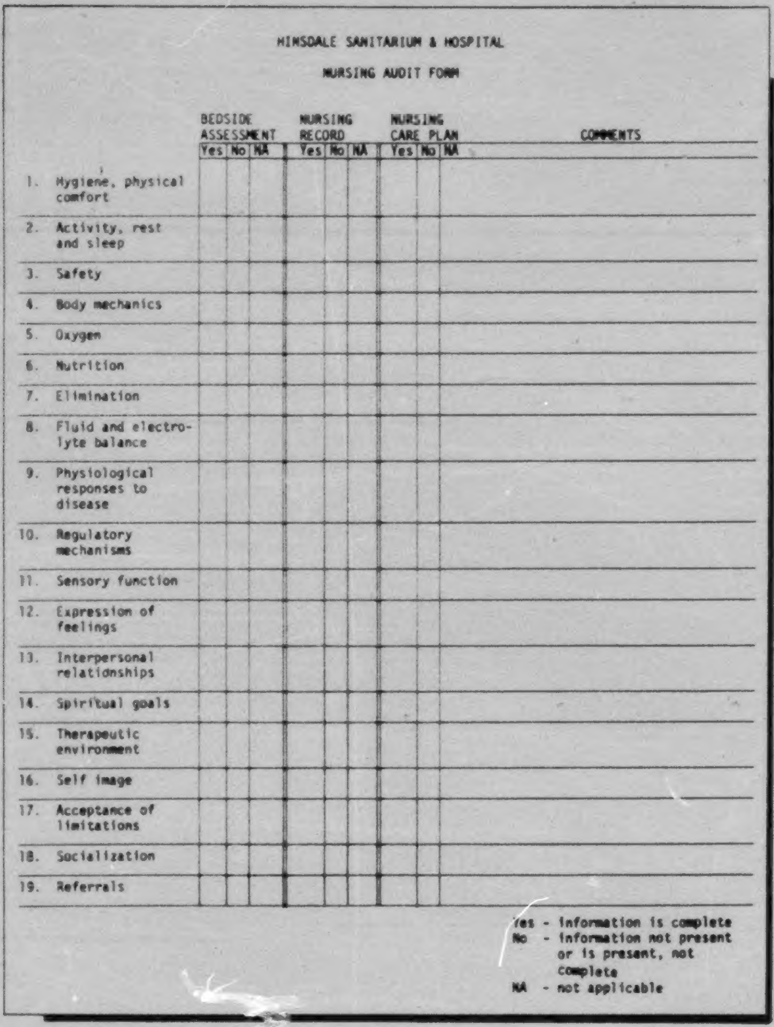

HINSDALE SANITARIUM & HOSPITAL

NURSING AUDIT FORM

	BEDSIDE ASSESSMENT			NURSING RECORD			NURSING CARE PLAN			COMMENTS
	Yes	No	NA	Yes	No	NA	Yes	No	NA	
1. Hygiene, physical comfort										
2. Activity, rest and sleep										
3. Safety										
4. Body mechanics										
5. Oxygen										
6. Nutrition										
7. Elimination										
8. Fluid and electrolyte balance										
9. Physiological responses to disease										
10. Regulatory mechanisms										
11. Sensory function										
12. Expression of feelings										
13. Interpersonal relationships										
14. Spiritual goals										
15. Therapeutic environment										
16. Self image										
17. Acceptance of limitations										
18. Socialization										
19. Referrals										

Yes - information is complete
No - information not present or is present, not complete
NA - not applicable

NURSING AUDIT FORM

mine just how this tool should be used. It seemed that auditing charts of discharged patients would be an effective means of improving the quality of care for future patients but would, of course, not be of help to the patient whose chart was being reviewed. Then why not audit inpatients, we asked ourselves, and help this patient as well as future patients? This would make the audit a real-life situation, one in which ideas could be instantly utilized. This also would allow for the addition of a third dimension: an interview with the patient as well as a review of his chart and care plan.

The audit form and the second form for explanation were presented at a meeting for all supervisors and head nurses. At this time, the group was requested to take a form, read it over, and add, subtract, or make any changes that they thought would make the form more usable. The same request was made during a meeting with the evening staff nurses. Suggestions were compiled, and the audit form was revised accordingly.

Sample auditing

Next, sample audits were conducted on each unit with the head nurse for that unit. After these audits were completed, an audit committee was chosen. This committee included a representative from the nursing development department, a medical unit head nurse, a surgical unit head nurse, a specialty unit head nurse (psychiatry), and a representative from nursing service as chairman. This committee began planning for implementation of the inpatient audit on a regular basis and reported back to the supervisors and the head nurses.

Several decisions were made during the first audit committee meeting. First, we decided that sample audits should be done on each unit during the evening and night shifts. If nurses on these shifts were to be involved in any way, they needed orientation, and sample auditing on all shifts would provide the orientation. We were hopeful that the results of the audit would be shared with all three shifts in conferences. Another decision was related to timing. The head nurse members of the audit committee needed more time to familiarize themselves with the forms, and they chose to carry out audits on their own units while the members from the nurs-

(Please turn to page 82)

The Author

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When you've got a simple thing like the Pap test,

it's criminal that any woman should run the risk of undetected cancer of the uterus.

Don't put it off

The Pap test is a simple little internal checkup that takes your doctor practically no time at all.

It can detect cancer of the uterus—one of the most common cancers in women—in time to do something about it.

Imagine, that's all it takes: a simple Pap test once a year. Isn't it incredible that some women just don't get around to it?

Look, right now, while you're thinking of it, why not call your doctor and make an appointment for a Pap test?

Don't be afraid.

It's what you don't know that can hurt you.

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ing development and the nursing service departments worked with the other units. One audit per shift on each unit was our goal for the following one-month period.

One night, four audits were conducted during the night shift. It was discovered that these audits were useful for orientation but were not practical as an audit for two reasons: It was not possible to conduct a patient interview, and, if a certain area of human need was not charted, it was not possible to determine if the reason for its omission was because it did not apply or because it had been overlooked. For these reasons, night auditing was omitted.

After several months of experimentation, our present audit procedure evolved. For us, the following seems to be the most usable, practical, and effective method:

- Audits are conducted one time per month on each unit during either the day or evening shift.
- Audits were conducted with the team leader, the licensed practical nurse or the nursing assistant, and the head nurse if she is available.
- Each member of the audit committee is responsible for initiating the audits each month on two or three units.
- The information obtained is used to revise the nursing care plan either during or immediately following the audit.
- The best times to conduct the audit seem to be 11 a.m., 1 p.m., 4:30 p.m., or 7 p.m. because the units are involved in fewer activities at these times.

Evaluation

After audits were conducted for one year, the time for serious evaluation came. We asked ourselves the following questions: Are we really accomplishing anything? Has care improved? Are we more aware of the total person for whom we are caring? Although we had no scientific tool by which to measure our progress, we could draw some conclusions and note areas for improvement.

During one of our earliest audits, we found a very complete chart and a very complete care plan. However, during the interview with the patient, a large area of small blisters was noted on the face. It was a Herpes infection that "everyone knew about," but it had not been noted in writing. We now are finding less of this. One failure in the system that was immediately discovered was in the area of pain. Patients' complaints were noted, but often the location of the pain and the effects of pain-relieving measures were omitted. We still find these omissions, but they are not so widespread or as often. Patient's bowel habits also were neglected. Many times, the occurrence or absence of bowel movements were not charted. As a result, a change was made in our charting procedure to stress when and how to chart these factors.

We are compiling a list of the weakest areas found in the audits. This list is to be an additional aid to our nursing development department in its planning of in-service programs. If one area is consistently weak on several units, it becomes a top priority item for in-service education.

Resistance to the auditing program has been minimal from the onset. Nurses respond to the audit as a help—a teaching tool—rather than as a threat. The audit form is often left on the unit for the nurses' use, and this seems to have reduced even the slightest hesitation or fear. The nurses know the basic philosophy for this procedure and that it will not be used in a future personal evaluation of their performance. Because of this, cooperation and trust have been established. Frustration over the time involved (approximately 20 to 30 minutes) rather than fear has become our largest deterrent.

Future plans include a systematic program for auditing charts from medical records. Although there are specific objectives that can be met by this method, we believe that the opportunity to audit inpatient records is valuable and meets our philosophy and objectives for improving patient care on an immediate and one-to-one level. ■

PEER REVIEW—

A Working Experiment

Two problems were identified: reluctance to judge and be judged, and the lack of established criteria as a baseline for evaluation.

HAROLD GOLD • MARJORIE JACKSON
BARBARA SACHS • MARGIE J. VAN METER

TWO influences led us to undertake our experiment in peer review at University Hospital, Ann Arbor, Michigan. The first was the fact that peer review is increasingly recognized, in nursing and other fields, as a measure of accountability and as a means of evaluating and improving standards of practice. The second was the fact that the clinical nursing specialist program initiated at our hospital by the department of nursing in July 1970, and periodically appraised since that time, needed a more thorough review.

Therefore, nine clinical specialists and the coordinator of the program conducted a formal peer review as part of the general program appraisal. All of us were masters prepared nurses holding staff positions in the nursing department. Our purpose was to critically examine our own practice and role development through validation by our colleagues.

Although there has been a great deal in the literature about the clinical specialist role, with the scope of such practice amply defined, nothing has been written about peer review of clinical specialization or, in fact, of nursing practice generally. Thus, we were using a new tool to appraise a new specialty—a challenging task.

THE DESIGN

Inasmuch as no clear definition or guidelines for peer review have been formulated, the design for the review was planned by three of the specialists: one each in medical-surgical, pediatric, and psychiatric nursing. Two key components seemed important: first, self-evaluation by each specialist and the coordinator and, second, a group interactional review. These components were then subdivided as shown on the opposite page.

Two sessions were planned for the review but first the self-evaluations were prepared, circulated, and read. Then, at the first group meeting, each specialist was allowed 30 minutes to amplify and clarify her written summary and to respond to colleagues' challenges. The order of individual review was by clinical area and seniority in the role, with the medical-surgical specialists first, pediatric specialists second, and psychiatric specialists third. As it happened, this ordering generally coincided with the length of employment of the individual specialists. The second group meeting was planned to be a half-day session devoted to a review of the coordinator's activities and a program analysis.

Since psychological threat is inherent in any evaluation, safeguards were planned, such as

- the guidelines formulated by the planning group were accepted by consensus by all the specialists;
- moderators from the planning group were to maintain time limits and focus of discussion; and
- the group interactional review was to be held away

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from the hospital in a comfortable climate for discussion.

Successful completion of the peer review was predicted on honest input, full participation, and a willingness to risk critical inquiry.

THE ACTUALITY

The specialists had been collecting data about their practice since the beginning of the clinical nursing specialist program, but the information had been used primarily for self-evaluation and as a base for semi-annual reports to the department of nursing. Now their task was to abstract months of experiential data in a relatively new nursing role, and then synthesize those data into meaningful descriptions of the role expressions.

Although the content of the summaries had been agreed upon, each specialist was free to develop his or her own format and style of reporting, so differences in role emphasis, stage of role development, and personality characteristics emerged. Some of the reports relied heavily on statistical data, while others were couched in a narrative style. Positive results were usually emphasized, with areas perceived as failures described in only three data summaries.

The data summaries were circulated and read, the group review called—and problems began to surface. We had all assumed that we were personally and professionally secure enough to risk individual criticism while participating completely and openly in the peer review process. This appeared to be a valid assumption, since we had been meeting regularly for two years to share problems, information, and projects. However, the first peer review session saw time and energy squandered on superficial problems, tentative challenges, retreat and regrouping maneuvers. The data summaries, conceived of as merely useful and factual information, sometimes became shields against probing, disquieting questions. At first, individuals were concerned about being objects of criticism. As the review progressed, however, it became clear that some found it even more difficult to criticize colleagues to their faces.

Nurses do not like to judge their fellow nurses. This is especially true for those who are creating new nursing roles. There can be repercussions, because there is no assurance that a challenge would not jeopardize working relationships or group membership. Therefore, only positive perceptions were spoken. Negative feedback was simply not presented. Any critical assessments took the form of self-criticisms, and the group then rallied to focus on the specialist's positive accomplishments. Other reasons for the superficiality of the discussion were probably the meager half-hour allotted to each specialist and the lack of understanding of the organizational climate in which others practiced.

When the individual presentations were completed, a sense of dissatisfaction prevailed and resulted in the identification of two problems: the lack of personal security and of established criteria for specialized nursing practice. We were then able to discuss the personal meaning of this peer review and to admit to feeling threatened when such highly charged subjects as competition, role comparisons, fear of failure, personal depletion, and abuse of the role and its privileges arose. As we shared feelings about these highly charged issues, we came to a renewed willingness to work through peer review and to honestly participate in it. We decided to devote a full rather than a half day to the second group session.

The second problem, lack of established criteria for nursing practice, was not dealt with so easily. In most instances, judgments about *role* problems were gone into more thoroughly than were judgments about *clinical care* problems. Quantification of activities in nursing practice was emphasized over quality of practice. It soon became apparent that multispecialty review in the area of content and clinical judgment was unmanageable. If the

DESIGN FOR PEER REVIEW

I. Individual summaries of own work
  A. Specialist self-evaluation
    1. Performance summary: data about the focus and scope of practice, activities that characterize role implementation, allocation of time and degree of role manageability, extent of organizational involvement other than direct patient care responsibilities, and professional growth and development
    2. Clinical impact summary: an objective [illegible] subjective report on the role's impact [illegible] the specialty area and the system within which the role was experienced
    3. Evaluation of relationships with other specialists: type of work involvement, support, value, et cetera
    4. Evaluation or relationships with one's coordinator(s): type of work involvement, support, value, et cetera
    5. Goals and objectives
  B. Coordinator self-evaluation
    1. Performance summary
    2. Clinical impact summary
    3. Evaluation of relationships with specialists and others
    4. Goals and objectives
II. Group interactional review:
    1. Evaluation and recommendations for each specialist
    2. Evaluation and recommendations for coordinator
    3. Review and establishment of new group goals
    4. Formulation of objectives for next evaluation

> *"Criteria that measure clinical effectiveness in terms of nursing process and patient outcomes* must *be developed before nursing practitioners can conduct an objective review by peers."*

specialized practitioner is to determine whether he/she is in a process of ascending competency and is incorporating into nursing care those aspects of medical science for which standardized nursing strategies have not been evolved, he must be able to measure himself against criteria established by colleagues in the same specialty area.

The coordinator's presentation of her data more easily met the need for concrete measurement and actively involved everyone. She had designed a numerical rating scale and asked each specialist to rank her (the coordinator's) achievements in facilitating the clinical nursing specialist role at our medical center. She used her objectives to delineate the areas to be evaluated. These included: providing a safe climate for innovative practice; setting expectations for self and specialists; encouraging problem-solving approaches; promoting scholarly practice; utilizing organizational resources in the implementation and acceptance of the role; focusing the role on patient care; stimulating professional growth; and promoting self-actualization. After the specialists as a group had rated her performance, the coordinator shared her self-ratings and provided an opportunity to discuss her role enactment.

The review of the total clinical nursing specialist program produced the most spirited and productive discussion. This may have been because it was personally less threatening, with the strengthened group cohesiveness permitting fuller participation and objective analysis. A more significant factor may have been that the review was based on shared understanding of the program. Useful recommendations were made for strengthening the program, and the group left the session, having worked through peer review, with new understandings and resolves.

OUTCOMES

The anticipated outcomes of our peer review had been objective validations of each one's role enactment by the other clinical specialists, or alternative proposals and new perceptions of one's self from group interaction. What peer review actually resulted in was the admission of primary personal safety needs, a stronger sense of group cohesiveness, and, finally, an intensified awareness of the scope and impact of the clinical nursing specialist program on the hospital, as reflected in the individual clinical impact summaries.

Our recommendations are obvious. Any group planning a peer review should minimize personal threat as was attempted in this experience. If it is recognized that the inherent personal threat is great enough to preclude a beneficial experience from the group review, the review process should certainly be halted and this issue dealt with before continuing.

Criteria that measure clinical effectiveness in terms of nursing process and patient outcomes *must* be developed before nursing practitioners can conduct an objective review by peers. These criteria should be developed by a panel of practitioners involved in the day to day care of patients in their respective specialty areas. The citeria should be regarded as expert consensus on recommendations for the best current practice, although this consensus will change as knowledge and nursing roles expand. The criteria should not be interpreted, however, as standards of nursing practice or of employee performance. Their value is educational and self-evaluative for the practitioners. Only with such criteria will peer review become an accepted means to examine and evaluate practice.

GUIDELINES

In summary, then, our working experiment has led us to a three-step concept, or model, for peer review: (1) establishment of criteria by consensus; (2) self-evaluation according to the criteria; and (3) group review. The steps must be taken in that order. We also identified peer review guidelines as follows:

- peer review should be a continuing process, not a contrived annual review
- peer review should be primarily specific to a clinical area or discipline, with the nurse specialists in that area having the option to involve nurses from other clinical areas as appropriate
- peer review should be oriented more toward the management of nursing care problems and less toward manageability of role
- peer review criteria should focus on nursing process and patient outcomes.

As the review process was a new venture for us, the experience consisted of learning by doing and raised issues of methodology, objectivity, and manageability. An established and a supportive climate of trust facilitates group process and communication in peer review, we concluded. But we believe that the concept will become truly operative only when acceptable means for nursing practitioners to examine and evaluate their own clinical performance are established. ■

SECTION B

CHART AUDIT SAMPLES

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The following is from the California Medical Association and California Hospital Association's manual, The CMA/CHA Patient Care Audit Workshop Program Manual, 1974.

PATIENT CARE AUDIT PROCESS

A Method for Improving the Quality of Patient Care

Select a topic for audit. The subject can be:
- -a diagnosis - e.g. myocardial infarction
- -a surgical procedure - e.g. cholecystectomy
- -a physical finding - e.g. high blood pressure
- -a symptom - e.g. swelling
- -an abnormal lab test result or x-ray
- -a social-psychological problem
- -a therapeutic measure - e.g. use of medication, blood transfusion

II. a) Establish criteria for audit of the topic chosen. Criteria should consist of 5 to 7 essential items pertaining to the subject which will indicate whether or not the group of patients in this category is receiving "good" medical care. These criteria are discussed and decided upon by physicians and other providers of care at your hospital. These criteria may be outcome criteria - e.g.; patient survived, length of stay; or they may be process (or treatment) criteria - e.g., justification of diagnosis, indications that the patient received appropriate therapy; or both outcome and process criteria.

b) Establish expected acceptable performance levels in terms of percentages for each criterion. These percentages indicate the "threshold for action." If the actual performance level for a criterion falls below that which is expected, there is commitment to taking action to correct the deviations.

III. Criteria are ratified by all providers whose performance is part of the pattern of care being examined. At this point, each provider is given a chance to agree to the criteria and/or to make changes in either the performance percentages or the criteria.

IV. The ratified criteria (those criteria agreed upon by providers whose performance will be included in the audit) are applied to chart review by the medical records administrator.

V. The medical records administrator presents the results of the data abstraction to the audit committee.

VI. The audit committee compares the expected performance percentages to the actual performance percentages as determined by the data analysis, and identifies areas of deviation.

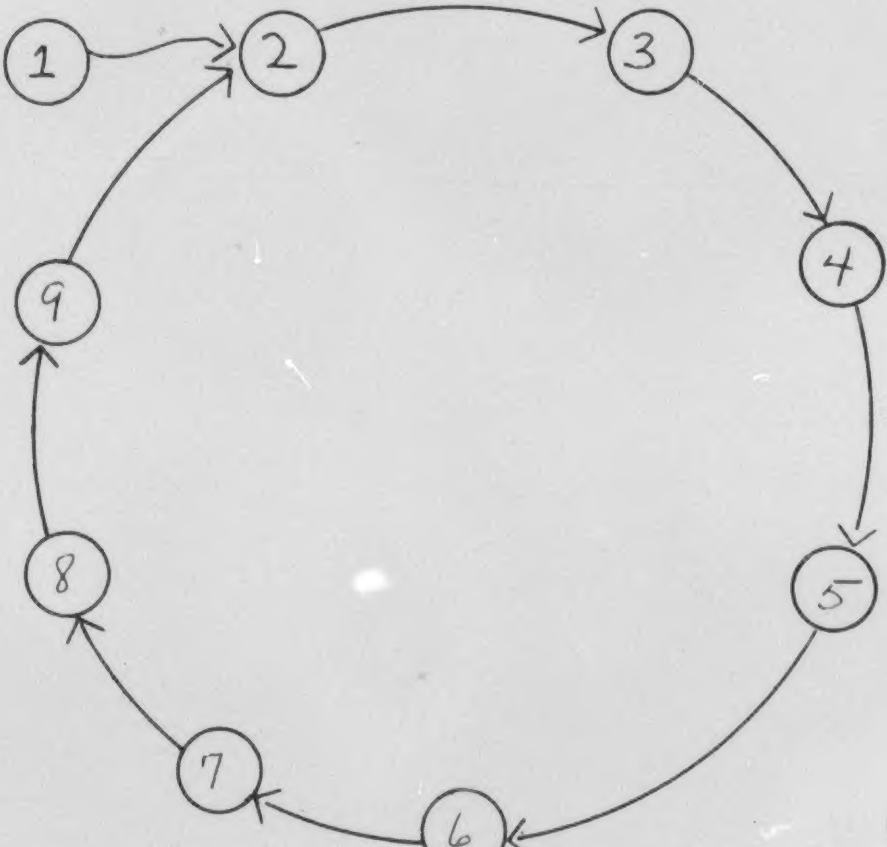
VII. The audit committee analyzes the deviations - e.g., does the problem exist because of lack of proper equipment, inappropriate organizational structure, lack of sufficient manpower, lack of motivation, lack of skill, and/or lack of knowledge?

VIII. Based on the problem analysis, the audit committee plans a remedial action program and supervises its implementation and monitoring.

IX. A re-audit is performed after a suitable interval to determine if the remedial action program results in raising the actual performance percentages, thereby improving the quality of care for this category of patients.

The following are some steps in the audit cycle. These steps are listed in random order. Refer to the diagram below and assign the appropriate number to each step.

- Re-evaluate patient care after suitable interval
- Compare actual performance with expected performance to identify areas of substandard care (problems)
- Implement and monitor remedial action
- Have draft criteria (or revisions) ratified by all those whose cases may be audited
- Analyze problems and establish probable cause(s)
- Develop draft criteria and expected performance levels
- Develop specific remedial action
- Select diagnosis, operation, or other basis for defining patient care to audit
- Apply criteria to chart review by Medical Records personnel.



B-2

SELECTING A TOPIC FOR PATIENT CARE AUDIT

The guidelines listed below have proved helpful in selecting problems for audit:

1. The "topic" for audit can be:

   - -a diagnosis (admission or discharge diagnosis)
   - -a surgical procedure
   - -a physical finding, i.e., swelling
   - -an abnormal lab test result or x-ray
   - -a social-psychological problem
   - -a therapeutic measure (use of a medication, blood transfusions)

   (Choice of the above will, no doubt, be influenced by what type of medical information and coding system is available)

2. Facets of patient care that can be looked at using the audit process are:

   - -justification for hospital admission
   - -diagnostic accuracy
   - -indications for surgery
   - -adequacy and appropriateness of treatment (management)
   - -adequacy of short range outcomes (complications, length of stay, patient education)

   (One or more of the above could be included in a single audit)

3. A topic should usually not be considered for audit unless several of the following conditions can be satisfied:

   A. High frequency, i.e., statistical evidence indicating that the topic is commonly seen in the hospital.

   B. Problem severity in the absence of medical intervention, i.e., if medical intervention is not forthcoming, a patient's life is threatened.

   C. Amenability to proper medical intervention, i.e., it has already been established that medical intervention can significantly alter the health of the patient by correcting or ameliorating disability, or preventing increased disability.

   D. Generally agreed-upon practices in the handling of the topic, i.e., topics that have too many controversial aspects in such areas as prevention, diagnosis, management and rehabilitation are not suitable for audit.

Audit is not clinical research. Rather it is a tool for:

1) Applying previously-verified practices to an individual care setting.

2) Bringing about action on the deficiencies revealed in the analysis.

E. Interest and enthusiasm in doing an audit on a topic, particularly in the initial period, when an audit committee is newly-formed and embarking on its first few audits, the kind of topics which often engender interest and enthusiasm may be someone's "hunch" about a problem in patient care or another person's "pet interest." The above considerations A-D could still be used to evaluate these "hunches" and "pet interests."

References:

1. Procedure for Retrospective Medical Care Audit in Hospitals, Joint Commission on Accreditation of Hospitals, 1973.

2. Kessner, David M., Kalk, Carolyn E., "Quality Assessment and the Tracer Method", (Presented to the American Public Health Association, November 15, 1972, Atlantic City, New Jersey)

GUIDELINES FOR CHOOSING AN AUDIT TOPIC OBJECTIVE

In general, the facet of an Audit topic chosen for auditing or the Audit topic focus should probably be one of the following:

1. That particular facet of patient care in which those doing the Audit feel a problem might exist, or
2. That particular facet of patient care that is generally known to be a problem in many other hospitals, and therefore may be a problem in that hospital doing the audit.
3. That particular facet of patient care within the Audit topic that most affects patient disability - that is, can correct or ameliorate disability. (Disability = mortality, morbidity, complications, increased L.O.S. in hospital special units, etc.)

   In other words, the focus of an Audit topic should be that area of the Audit topic most likely to reveal at least one problem in patient care or most likely to affect patient disability and therefore, be the most fruitful for improving patient care.

In order to establish a focus for an Audit topic, those doing the Audit can ask themselves the following questions:

1. Do you suspect there may be a problem anywhere in the diagnosis, treatment, or outcome of patients within this Audit topic?
2. What are the major patient disabilities that could occur around this Audit topic? (mortality, morbidity, complications, increased L.O.S. in special units, etc.)
3. What are the probable causes of these disabilities? (Inadequate work-up, poor patient control, etc.)
4. Which of the disabilities are preventable?
5. Which of the disabilities may not be being prevented because of lack of application by health care professionals of available resources?
6. What aspect of the Audit topic interests those doing the Audit; what do they want to examine more closely or what do they have a hunch that may reveal a problem?

SETTING CRITERIA AND EXPECTED LEVELS OF PERFORMANCE

Purpose: The first criteria setting session of the workshop exposes participants to concepts, procedures, and terminology of Patient Care Audit which will be reinforce during the second cycle. Specifically participants will have initial learning experiences in:

1. Selecting a topic for audit.
2. Defining the parameters of the patient population which will be audited.
3. Defining the focus or aspect of patient care to be audited.
4. Selecting and writing criteria.
5. Defining and establishing percentages of expected level of performance for each criterion.
6. Recognizing that the criteria established by the Audit Committee are draft criteria which may and probably will be changed when presented for ratification.

Outcomes:

1. The team will have read the handout "Selecting a Problem for Patient Care Audit".
2. The team will have defined the parameters of the patient population being audited for the first disease.
3. The team will have established an objective (reason) for conducting the audit of the first disease.
4. The team will have established criteria which meet the requirements as outlined in the procedure.
5. These criteria will be indicators of the quality of care which are unique and essential to the patient population being audited and are not cast in concrete.
6. For each criterion, the group will have established an expected level of performance below 100% or above 0% which acts as the "threshold for action".

Procedure: How to select a topic for audit

1. Instructor explains how to choose a topic for audit.

Techniques

a. Refer to handout "Selecting a Problem for Patient Care Audit".

b. Go through the handout with the team.

c. Point out to the team that this might prove a useful guide if, when they return to their hospital, they wish to begin implementing this type of Audit.

d. Ask if they have any questions.

2. Ask the team to choose for their first workshop cycle one of the two sets of charts they brought.

Techniques

a. Ask team how they decided what two topics to bring.

b. Point out that if this were their own hospital they would not be limited to two topics but could choose anything.

c. Point out that we had to ask for only two topics of 15 charts each for logistical reasons. The medical records person does not in this setting have access to all of her records.

Procedure: Defining the parameters of the patient population

1. Instructor explains that part of selecting a topic for audit includes defining the parameters of the patient-population to be audited including:

    -Age limits to be considered - e.g., if the subject for Audit were pneumonia, would they want to exclude pediatric cases.
    -Are only primary diagnoses to be included
    -Does surgical approach make any difference - e.g., abdominal vs. vaginal hysterectomy.

Instructor explains that this needs to be done so that we are all talking about the same topic.

Techniques

a. Ask medical records person how she pulled the 15 charts. Did she make any exclusions? What did she include?

b. Ask team if there is anything they want to exclude.

Procedure: Defining the focus or aspect of patient care to be audited

Option I: Instructor explains that establishing an objective or reason for conducting the Audit enables the committee to:

- Focus on that particular facet of patient care where they believe a problem might exist.
- Define, clearly, what they want to look at.

Techniques

a. Instructor writes on the flip chart the following questions the team could ask themselves when establishing an objective:

1) Do you suspect there may be a problem anywhere in the diagnosis, treatment, or outcome of patients with this disease or surgery?

2) What are the patient disabilities that could occur? (Mortality, morbidity, complications, L.O.S. in Special Units)

3) What are the probable causes of these disabilities? (Inadequate workup, poor patient control, etc.)

4) Which of the disabilities are preventable?

5) Which of the disabilities are not being prevented because of lack of application by physician and others of available resources?

6) What is it that you want to examine closely?

Option II: If the team exhibits difficulty in defining the objective, go on to brainstorming criteria. It may be that once they have brainstormed criteria, then selected their most important criteria, the objective will become clear to them - e.g. If their prioritized criteria are "pt. demonstrates knowledge of now to change dressing", then their objective might be "to determine if patients received appropriate education prior to discharge".

Procedure: Selecting and writing criteria

1. Instructor should define "criteria" for the team as those essential items which act as indicators of the quality of care which patients in this category (M.I., Pneumonia, etc.) are receiving. Criteria may be:

   a. Outcome criteria - patient survived, complications, morbidity, L.O.S.;

   b. Process criteria - justification of diagnosis, indications that patient received appropriate therapy; or

   c. Both outcome and process.

2. Begin establishing criteria. Explain that although in the workshop we will set criteria which use the chart as the source of data, in their own hospital they may set criteria which will require other sources of data.

Techniques

Option I: "BRAINSTORMING"

a. Tell participants they will "brainstorm" criteria. Using the process of "brainstorming elicits more suggestions, at a more rapid rate, from every participant in the group.

b. Explain rules of "brainstorming".

   1) Each person suggests whatever comes to mind as indicators of the quality of care.
   2) No one is allowed to evaluate or comment on any of the suggestions.
   3) Suggestions must not be categorized as part of the history, physical, outcome or anything else.

c. During "brainstorming" there will be a point at which everyone becomes silent. Do not intervene. They will produce a second surge of ideas.

d. Write each suggestion exactly as stated on flip chart. When page is full, tear off, tape on wall and start a new page.

e. Tell each participant to choose the two items from the list that they feel are the most essential indicators of the quality of care. Ask "Which two items if missing from the chart would make you feel most anxious about the quality of care?"

Option II: "DELBECQ"

a. Tell the group they will set criteria using the "Delbecq" method. This process encures that everyone participates, not just those ot just those individuals who talk the loudest and the fastest.

b. Explain rules of Delbecq.

   1) Everyone takes 15 minutes to silently, with no discussion, write down those items which they consider to be indicators of the quality of care.

   2) Then we go around the room and each person gives one from their list. This continues until all items are listed on the flip chart.

   3) While going around the room no one is allowed to comment upon or evaluate any of the items.

   4) Once all items are on the flip chart, there can be a period of discussion where each item is commented upon. This period will last no more than 15 minutes.

c. Following the implementation of the above steps, each individual is asked to choose the two items that they feel are the most essential indicators of the quality of care. Ask "Which two items if missing from the chart would make you feel most anxious about the quality of care?

3. Instructor explains that criteria must now be clarified.

Technique

a. Instructor writes on flip chart guidelines to follow:

   1) Each criterion should be a complete thought rather than a phrase - e.g., instead of "Chest X-ray", do you mean "Chest X-ray ordered", "Chest X-ray done", "Chest X-ray negative."

   2) Each criterion should be understandable whether or not it is written in medical terminology.

   3) Each criterion should include:

      a) the frequency of an activity - e.g., "temperature recorded every 4 hours."

      b) the time limit for an activity to occur - e.g., "chest X-ray taken within 24 hrs. of admission"

c) the exclusions or limitations of the criterion - e.g., all suspected M.I.'s admitted to the E.R. should be on a monitor within 30 minutes, except those who require defribillation in the E. R.

4) Is each criterion:
Relevant to the quality of care
Understandable
Measureable
Behavioral
Achievable

b. It is good to elicit the participation of the medical records person at this point. Try to get her to ask the questions for which she requires answers in order to get the data from the chart.

Procedure: Defining and establishing percentages of expected level of performance

1. Instructor defines "expected level of performance" for the team, including:

   a. the "threshold for action" (not just a review of charts but a major action requiring use of resources)

   b. the point at which you would become anxious about the quality of care

2. Instructor explains why the expected level of performance is set, including:

   a. to have some objective way of determining when action to improve patient care must be taken. Later, the actual level of performance will be compared with the expected level of performance to determine where problem areas might exist.

   b. to ensure that all whose performance will be audited know to what extent the criteria will be applied.

   c. to indicate the worth of the criterion.

   d. to commit the group to look at the criterion if the actual level of performance is lower than the expected level of performance.

   e. to set up a dissonance if "d" occurs in order to lead to change.

3. Instructor asks group to establish an expected level of performance for each criterion.

EXPECTED PERFORMANCE LEVELS

One of the most practical and effective features of the CMA/CHA Educational Patient Care Audit system is the use of an Expected Performance Level associated with each criterion. Where some of the alternative methods of audit advocate that all criteria should be "100%" and all possible exceptions listed (a formidable task), we encourage hospital audit committees to draft realistic, attainable levels, and thus start at the point where other methods arrive, after painstakingly listing all the possible (or unusual) exceptions. Not only does this save a great deal of time, and simplify the audit system to the point where it can become practical and useful, it also has the advantage of providing a focus for change - the expected performance level is a threshold for action.

What does it mean, when an audit committee recommends an expected performance level of, say 75% for a criterion that "All patients over 40 years of age will have recorded on the chart a standing BP"?

It does not mean that care can be assumed to be perfect, nor even that it is satisfactory, if that expected level is met or exceeded. Conversely, it does not mean that care is unsatisfactory or poor if it is not met. It also does not mean that the audit committee should look at all the charts where the criterion is not met.

What it does mean is that if fewer than 75% of patients in this group have a standing BP recorded, and if this criterion has been ratified by the medical staff, then the medical staff is committed to do something that will ensure that at least 75% of the next (comparable) group of patients will have standing Blood Pressures (done and recorded) on a re-audit.

It is apparent that the emphasis and effect of this system is forward-looking and goal-oriented. The intent is simply to improve the quality of care. If the intent were to look back to try to fix blame or conduct a "post mortem" then perhaps it would be necessary to assign a "100%" level to each criterion and list all exceptions. But if the intent is to improve care from now on, it is only necessary to set an attainable level of performance, with consensus and the commitment of all concerned, ascertain whether it is being met, and if not, take the necessary steps to see that it will be met.

The expected level can be raised on subsequent re-audits. The eventual goal for many (but not all*) criteria should be 100%, but in order to ensure that the expected performance level is indeed a signal for positive, affirmative and effective action, we emphasize that it should be realistic and attainable.

* For example, appendectomy criteria for lab usually include a level of 80% "hot" vs 20% "cold".

Expected Performance Levels

The level should be suggested (drafted) by the audit committee immediately after the criteria. Both criteria and associated expected levels of performance should be ratified (one by one) by all members of the hospital staff who are affected, i.e., whose patients will be included in the audit, and who do or order any of the procedures or actions which are the subject of a criterion or criteria. Only when all of the criteria and expected performance levels have been unanimously approved (after modifications and refinements duly voted upon) do they become criteria, and then commitment is welded to the criteria and to the expected performance levels. Such commitment is almost certainly lacking in those methods of audit which require 100% for everything, and where criteria are developed and presented as a "fait accompli" to the hospital staff (or not presented at all!).

Finally, the setting of expected performance levels helps in the definition of criteria. For example a criterion which really should be associated with 100% performance is probably something that should be included in standing orders (and therefore should not be used as a criterion at all) while a 50% expected performance level denotes that a criterion may not be very important, if it causes no discomfort to the audit committee that something does not happen (or get on the chart) half the time.

It has been suggested that expected performance levels should be regarded, not only as thresholds for action, but also as "levels of discomfort". If the audit committee sets a level of 75% for a particular criterion, in addition to recommending that action be taken if 75% of the charts do not contain that particular datum, the inference is that the committee would be "comfortable" about the quality of care as indicated by the criterion at that level, and is "comfortably" confident that the charts will reflect it. The suggestion then, is that that level should not be set at 75% but possibly at 80% or 85% as the level of discomfort, to ensure that the criterion sharply delineates the parameter it is designed to measure. Regardless of whether this latter suggestion is followed, the expected level of performance is one of the most useful features of Educational Patient Care Audit.

PATIENT CARE AUDIT

CRITERIA

Department (or Service):

Topic of Audit:

Parameters of Patient Population:

ICDA Code:

Objective of Audit:

CRITERIA	EXPECTED LEVEL OF PERFORMANCE
1.	
2.	
3.	
4.	
5.	

RATIFICATION

The educational patient care audit process has been neatly characterized in three words: "Criteria with Commitment." It is at the ratification stage that the commitment is welded to the criteria. No matter how sharp and clear the objective, no matter how cogent and sophisticated the criteria, an audit is an excercise with little meaning until the criteria (and associated "expected performance levels") are ratified by those who must be concerned. Many audit programs have floundered on this rock. Often the means used by an audit committee to avoid ratification, while subtle and ingenious, fail in the most important areas of involvement and participation, the only means we know to motivate a hospital staff to initiate and carry out a systematic program which entails change.

The typical ratification session will include all the individuals whose actions make up the totality of patient care with respect to the topic being audited. Prior to the session all should be notified that the topic will be under discussion and asked to be prepared to discuss "what should be happening, in this hospital" with regard to the topic. The session may be opened by the chief of staff, who introduces the audit committee chairman and specifies the ground-rules for the session. Usually the audit committee chairman will be permitted to present the topic and objective of the audit, and display the draft-criteria, each with an associated "expected performance level", preferably without discussion or criticism. He may explain some of the logic employed by the audit committee in limiting the topic, but if he is wise, he will not explain each individual criterion or performance level until questioned. A second presentation, with discussion, should then take place, and each member of the hospital staff, who is to use the criteria, then has the opportunity to accept, reject, modify, send back to committee or suggest additional or substitute criteria, expected performance levels, or objectives for the audit.

The outcomes of the ratification session, provided it is carried out in a reasonably cooperative spirit and provided there is an honest commitment to try, will include the achievement of consensus. It may seem difficult to believe before one has attempted it, but frequently a department staff will hammer out criteria and expected performance levels which they are able to approve unanimously. As a "rule of thumb" the criteria should not be intact when ratified. If they are exactly as framed by the audit committee or if ratification is accomplished too easily, this may be an indication that the criteria are too low, or that they are not being "adopted" by the staff. The ratification session should be characterized by discussion, give-and-take, even "horsetrading." The audit committee should be prepared to drop a criterion or two, modify others, change expected performance levels, whatever is needed to achieve consensus. In some instances unanimity may not be possible, but provided that individuals or "minority opinions" are logical and reasoned, the discussion will be mutually respectful and will tend toward consensus. Above all, it will be an educational experience for all who participate, and it will result in attention drawn to criteria which the audit committee suggests, even when these are not ratified.

Ratification

In a practical way, many hospitals are now including nursing staff, record room personnel, pharmacists and other health professionals in audit committees and ratification sessions where non-medical criteria are included in patient care audit. Generally there is very little risk that a non-physician will intrude opinions on strictly medical matters, and often a non-physician can provide valuable assistance in the development of the audit, where the duties and expertise of a non-physician are often critical factors in patient care. This is all the more appropriate when one reflects that this is patient care audit --not "medical" audit, nor just chart review.

When the hospital staff becomes convinced that the intent and design of the audit is not punitive, that it is concerned simply with documenting the ever-improving quality of patient care, and that it is educational and fun, the popularity of our ratification sessions will be enormous.

UNITED HOSPITALS, INC.

MILLER DIVISION

PSYCHIATRIC OCCUPATIONAL THERAPY

Explanation of Documentation Review

At United Hospitals, Inc., St. Paul, Mn., the Problem-Oriented Medical Record (POMR) is utilized. Each discipline charts on common Patient Care Progress Notes using the S.O.A.P. format. In addition, each discipline may also use some type of flow sheet to record daily treatments in a check list fashion. In psychiatric occupational therapy a flow sheet is used for each patient. (See attached.) In addition, each therapist charts weekly (S.O.A.P.) on all her patients, or oftener as necessary. Every other month, one staff member reviews the documentation of all other staff, and this job is rotated to all staff. The charts of two patients per therapist are drawn at random for review. To make the review as simple as possible all questions were set up for yes or no answers, with the preferred answer being yes in all cases. A rating is based on the percentage of yes answers to the total number of questions answered. After a trial basis, it was decided that the minimal acceptable rating for a therapist was 70% yes on Documentation Review.

Submitted by:

Lita Fike, OTR
Director
Occupational Therapy Department

UNITED HOSPITALS
MILLER DIVISION
PSYCHIATRIC OCCUPATIONAL THERAPY

DOCUMENTATION REVIEW

General

1. Was the patient seen within 24 hours of referral? (or 48, if referred on the week-end).

Yes________ No__________

2. Was Treatment Plan on Flow-Sheet within 48 hours of referral?

Yes________ No__________

3. Was initial note written on the chart within 72 hours of referral?

Yes________ No__________

4. Are the progress notes (S.O.A.P.) written within 10 days of previous note?

Yes________ No__________

Comments:

Problems:

1. Does the statement of Problems on the Flow-Sheet agree with list on Medical Chart?

Yes________ No___________

2. If the major admitting problem is complex, has it appropriately been subdivided for clarification and planning?

Yes________ No___________

3. If progress note concerns new problem, is Problem circled in red and added to chart list and flow sheet?

Yes________ No___________

4. On progress note, is listed problem appropriate for the rest of note?

Yes________ No _____________

Comments:

Subjective:

1. Are all statements under (S) related to verbal material by the patient?

Yes__________ No____________

2. Does the material relate to patient's problems, his work in O.T., or himself?

Yes__________ No____________

Comments:

Objective (O):

1. Are all statements under (O) concrete, factual observations of therapist? (No appraisal or subjective material allowed.)

Yes_________ No___________ N.A.__________

2. Is there material relating to patient's:

   a.) appearance: Yes_____ No_______

   b.) attitude/judgement: Yes_____ No_______

   c.) work skills: Yes_____ No_______

   d.) social skills: Yes_____ No_______

3. Is material specific as to #2, above?

Yes________ No_______

4. Does material compare previous behaviour to present observations? (record progress?)

Yes_______ No_______ N.A.________

Comments:

Appraisal (A):

1. Are all the statements under (A) related to (S) and/or (O)?

Yes ________ No_________

2. Does material summarize patient needs or problems?

Yes __________ No ________

3. Does material contain assessment of O.T. treatment, interaction or plan?

Yes __________ No ________

Comments:

Plan:

1. On the Flow-Sheet, is there a Plan for each stated Problem?

Yes ________ No ___________

2. Does the Plan correspond to goals checked by doctor on the referral?

Yes ________ No ___________

3. In the progress note, does the Plan (P) relate to (A)?

Yes_________ No ___________

4. Does the plan reflect current O.T. theory and practice?

Yes _______ No ___________

5. Does the Plan reflect specific proposed O.T. intervention? (No goals or end-products allowed. Must be programs of action.)

Yes_________ No __________

6. Does the Plan include precautions when appropriate?

Yes _______ No __________ N.A. _______

Comments:

Additional:

1. Is correct grammar, spelling and punctuation used? (list errors)

Yes _________ No _______

2. Is correct medical and professional terminology used ? (List errors)

Yes _________ No_________

3. Is note legible, easy to read?

Yes __________ No _______

4. In the chart, has each note been designated as "O.T. Note" in some way?

Yes _________ No _________

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MR - 164

PROBLEMS:

O. T. PLANS:

DATE	TREATMENT												TECHNIQUE												MEDIA	SIGNED
	Task Group	Art Lab	Unit Project	1:1 Clinic	1:1 Room	Eval.	Large Clinic	Small Clinic	Remot & Reor.	P—M Train.	Pre-Voc.	No Treat	Gross Motor	Fine Motor	Menial Task	Service	Creative	Structured	Repetitive	Fail-Proof	Challenging	Short-Term	Long-Term	ADL		

TREATMENT GOALS DISCUSSED WITH PATIENT

B - 22

PSYCHIATRIC OCCUPATIONAL THERAPY

UNITED HOSPITALS, INC.
MILLER DIVISION
PSYCHIATRIC OCCUPATIONAL THERAPY

Explanation of Patient Care Review

In addition to a review of documentation, the psychiatric occupational therapy staff also reviews the care of their patients in a more direct manner. At the time of documentation review, the patient care review form is handed out to two patients of each therapist, and the instructions are followed. Again, a percentage of preferred answers to the total number of answered questions is used as a rating, and 70% is considered the minimal acceptable rating. All peer reviews are then reviewed by the director of occupational therapy and are used at the time of performance evaluation.

United Hospitals, Inc.
Miller Division
Psychiatric Occupational Therapy

PATIENT CARE REVIEW

Instructions:

1. THIS PT. CARE REVIEW SHOULD BE ADMINSTERED TO NON-EST PATIENTS ONLY!

2. Questionnaire should be handed to patient, with the following words of explanation:

> "We are interested in improving O.T. and in making it as helpful as possible to future patients. It would help us if you could give us some information by filling this out. You don't have to sign your name, if you don't want to"

3. When patient hands it back, the person doing review should check to make sure all questions are answered. If any are blank, the questionnaire should be handed back to patient, with the words:

> "Please. Try to write something."

4. If the patient is unable to fill out questionnaire or refuses, another patient should then be chosen for valid review.

Scoring:

Scoring will consist of rating answers as preferred (P) or not-preferred (NP), and establishing a total or percentage of preferred answers.

1. P: Yes and correct name. NP: No, and/or wrong name.

2. P: Yes, and realistic answer. N P: No.

3. P: Yes NP: No

4. P: (Examples)
   "to relieve tension - to relax me."
   "to help me not be so perfectionistic."
   "to get rid of my anger."
   "to get over being so down."
   "to learn something I can do at home."
   "to take my mind off my problems."
   "socialization, or group integration." Etc.
   NP: (Examples)
   "to keep me busy."
   "to occupy my time"
   "to keep me out of trouble"
   "because I have to " Etc.

5. P: Yes NP: No

6. P: Yes NP: No

7. P: Yes NP: No

8. P: Something that relates or supports answer #4.

9. P: Yes NP: No

10. P: Yes NP: No

11. P: More than three

12. P: Yes NP: No

13. P: Yes NP: No

14. P: Yes NP: No (N.A. if early in hospitalization.)

15. P: Yes NP: No

16. No preferred answer, but negative remarks call for consultation with the therapist being reviewed.

United Hospitals

United Hospitals, Inc.
Miller Division
Psychiatric Occupational Therapy

Patient Care Review - Questionnaire

1. Do you know the name of your therapist?

   Yes ______ No ______ Name _________________

2. Did your therapist tell you when you were scheduled to be in O.T.?

   Yes _____ No ______ When? _________

3. Did your therapist discuss why you are to attend O. T. ?

   Yes ______ No ______

4. What did she say?

5. Did your therapist ever talk to you about the reasons for your hospitalization?

   Yes ______ No _________

6. Did your therapist ever discuss your feelings about working in O.T., or how you felt about your O.T. activities?

   Yes _______ No_________

7. Did your therapist ever set O.T. goals with you?

   Yes ______ No _________

8. If yes, what were your goals ?

9. Did your therapist ever ask you to work on an activity other than one you chose yourself?
   Yes ______ No _______

10. Did you ever attend Task Group or Art Lab?

    Yes ______ No ________

11. About how many times?

12. Did your therapist ever discuss your feelings about working in Task Group or Art Lab?
    Yes _______ No _______

13. Did your therapist ever discuss your progress in O.T. ?

Yes ______ No _________

14. Did your therapist ever discuss your plans after discharge?

Yes ______ No _________

15. Did O.T. help you during your hospitalization?

Yes ______ No _________

16. Do you have any comments about O.T. and the supervision you received from your therapist? Anything else you would like to add?

University Hospitals of Cleveland
Occupational Therapy Department
Peer Review Form

Patient's Name ____________________ Therapist ______________
Hospital Number ____________________ Date of Review ______________
Age __________ Sex __________
Diagnosis ____

I. PRELIMINARY INFORMATION (from OT chart - check with Med Chart)	S	U	COMMENTS
A. Diagnosis Stated			
B. Reason for Adminission			
C. Ambulatory Status (if appropriate)			
D. Pertinent Medical and Social History			
E. Precautionary Information (if applicable)			

II. INITIAL O.T. NOTE (O.T. CHART)	S	U	COMMENTS
A. A formal initial note is written prior to 4th treatment			
B. Objective Findings and Evaluations (as applicable) 1. Joint ROM			
2. Muscle Evaluation			
3. Sensory			
4. Self-Care			
5. Sensory-Motor (List spec. eval.)			
6. Other (please state)			
C. Subjective Findings 1. Mental Status			
2. Emotional Status			
D. Other Pertinent Data Included			

III. PATIENT TREATMENT PLANNING (O.T. CHART)	S	U	COMMENTS
A. Goals of therapist are clearly stated and appropriate for this patient			
B. On-going treatment record is kept on charting notes recording pertinent information, observations and general treatment plan			
C. Record of recommendations and/or consults given to other professionals (Nursing, P.T., etc.) is kept			
D. Record of recommendations and/or consults given to patient's family or community agency is kept			

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S = Satisfactory
U = Unsatisfactory

IV. PATIENT PROGRESS (OT CHART)	S	U	COMMENTS
A. Patient's status in O.T. is recorded in a formal progress note every 7 to 10 treatments			
B. Patient is re-evaluated as appropriate			
C. Changes in goals/treatment planning etc. are made according to results of above and recorded			

V. DISCHARGE NOTE (OT CHART OR MED CHART)	S	U	COMMENTS
A. Formal discharge note is written within 4 days of discharge or discontinuation date			
B. Included total length of treatment and inclusive dates			
C. Summarized result of treatment			
D. Summary of patient's final evaluation/status at discharge is recorded			
E. Recommendations and/or instructions are included for home program, VNA nursing home, BVR, etc. (if appropriate)			
F. Reason for discontinuation included			

VI. RECORD REQUIREMENTS	S	U	COMMENTS
A. Basic Data Sheets/attendance records are filled out correctly and are up-to-date			
B. Evaluation forms are filled out correctly and dated			
C. Formal notes are neat, legible and grammatically correct			
D. Formal notes are concise			
E. Observation charting notes are initialed by appropriate person			
F. Formal notes are signed by responsible therapist			

UHC/OTD
4/74

University Hospitals of Cleveland

University Hospitals of Cleveland
Occupational Therapy Department

Occupational Therapy Patient Record Standards

I. Objective:
  A. To have a system for objectively evaluating:
    1. O.T. personnel performance in maintaining patient records.
    2. Level of performance in patient care.
  B. To have a standard by which O.T. personnel can be counseled in patient related responsibilities.
  C. To have a standard by which recognition and/or discipline can be given to O.T. personnel.

II. Method:
  A. O.T. supervisors will complete a written check of his/her assigned staff O.T. charts weekly on the appropriate form.
  B. O.T. Department Director will randomly audit all O.T. charts and supervisor's check-lists.
  C. Check-lists will be kept confidential for each employee and will be a part of the O.T. personnel file submitted with the End of Month report.
  D. Personnel with unsatisfactory ratings will be subjected to counseling and discipline for repeated offenses.

Standards of Records

	Satisfactory Ratings	Unsatisfactory Ratings
Basic Data Sheet	Completion of basic data on date, charting notes up-to-date. All basic data sheet items legible	Late Information in doubt
Evaluation	Appropriate for condition	Inappropriate
Formal note	Done on schedule according to peer review guidelines	Late
Initial note	Follows guidelines stated in peer review procedures	Does not meet procedures as stated in peer review
Progress note	Follows guidelines stated in peer review procedures	Does not meet procedures as stated in peer review
Discharge note	Follows guidelines stated in peer review procedures	Does not meet procedures as stated in peer review
Observation	Nature of current activity Precautions current (Change of behavior (significant remarks (Reason treatment did not (occur Stated in behavior terms Initialed note	Absence of nature of activity Negligence potential (Lack of observation so (behavior of patient can (not be interpreted Stated in subjective terms Not initialed

Comments: Add with an asterisk symbol notation to identify counseling points. For related item use reverse of page or extra paper. Use personnel form #5-1849-2 to verify repeated counseling as appropriate.

UHC/OTD
5/74

Occupational Therapy Patient Record Standards Check List

MONTH	PERSONNEL					
PATIENT	WK	BD	EV	FN	ON	COMMENTS
	1					
	2					
	3					
	4					
	1					
	2					
	3					
	4					
	1					
	2					
	3					
	4					
	1					
	2					
	3					
	4					
	1					
	2					
	3					
	4					
	1					
	2					
	3					
	4					
	1					
	2					
	3					
	4					
	1					
	2					
	3					
	4					
	1					
	2					
	3					
	4					
	1					
	2					
	3					
	4					
TOTAL "S"						
TOTAL "U"						

Mark "S" for satisfactory and "U" for unsatisfactory

BD Basic Data filled out as in "Systems Instructions"

EV Evaluation - mark type (abbreviate) and mark "S" or "U"

FN Formal note - mark "I" for Initial, "P" for Progress, "D" for Discharge and mark "S" or "U"

ON Observation note - mark "S" for satisfactory or "U" for unsatisfactory

Use asterisk type symbol to tie the comment to rating. All unsatisfactory ratings must be commented upon. Satisfactory ratings may be qualified with comments.

UHC/OTD
5/74

Peer Review Workshop/AOTA
Midyear Meeting, Tucson, 1974

POTENTIAL MODEL FOR CASE EVALUATION OR RECORD AUDIT....
in
OCCUPATIONAL THERAPY SERVICES

Scoring		yes/no	Points
	I EVALUATION		
	a. Is there evidence that systematic observation was used?		
	b. Have appropriate assessments been made from the possible three areas, developmental, behavioral and physical-biological?		
20	c. Was interview data recorded? Was there evidence of a pre-determined interview format?		
	d. Was an analysis made of the results of evaluation?		
	e. What was the quality of that analysis?		
	II PATIENT NEEDS		
15	a. Was there a summation of the patients assets and liabilities based on the data?		
	b. Were specific needs identified?		
	III GOALS OF TREATMENT		
	a. Are goals based on the preceeding data?		
	b. Are the goals addressed to specific functional gains?		
20	c. Are they both short term and long term?		
	d. Are they realistic in view of the time/resources available for service?		
	IV TREATMENT PLAN PROGRAM		
	a. Are specific, measurable strategies proposed?		
25	b. Are they addressed in priority?		
	c. Are they practical in view of the available data?		
	d. Do they appear appropriate for the condition/needs identified?		
	V OUTCOMES		
	a. Have specific outcomes been recorded?		
	b. Are they quantifiable? Are they consistent with program goals?		
20	c. Has the treatment program been altered to meet changing needs? Is there evidence of ongoing evaluation?		
	d. Have appropriate recommendations been made for ongoing service or discontinuation of service?		

Total Sc

Evaluator____________________

Date________________

Oak Forest Hospital
15900 South Cicero Ave., Oak Forest, Illinois 60452
Chicago (312) 928-4200 / Oak Forest (312) 687-7200

March 10, 1975

American Occupational Therapy Association - PER Division
6000 Executive Boulevard
Rockville, Maryland 20852

Re: Peer Review

The Occupational Therapy staff at Oak Forest Hospital has recently refined its method of Peer Review through chart audit. Although we are still in the pilot stages of this program, we felt that we should share what information we have with you.

Enclosed you will find one document entitled "Charting". These are the rules and regulations that we have set down for our staff. The second form is the "Check Sheet" that the supervisors use in evaluating patients. This form remains has part of the departmental chart. We audit active patients for several reasons.

The first is that being primarily an extended care and intermediate care level facility, our discharge rate is low compared to an acute facility.

A second reason is that due to the extended length of stay of so many of our patients, we want to ascertain that they are getting quality treatment throughout their stay.

One of the problems that we see our system having is that it does not have the confidentiality factor that should ideally be a part of Peer Review. However, the general opinion of the staff is that it's extremely helpful to them and we feel that during the three months this program has been in effect, we have seen gains in the quality of care that our department has been giving.

Please feel free to write with any questions or suggestions and we will try to keep you informed of any major changes that we make in our approach to the very important function of Peer Review.

Sincerely,

Melanie T. Ellexson

Melanie T. Ellexson, OTR
Director
Department of Occupational Therapy

/jq

Enclosures: 2

Health and Hospitals Governing Commission of Cook County

COMMISSIONERS: Edwin L. Brashears, Jr., Chairman; Charles A. Davis, Secretary; Mrs. W. Miles Burns; John W.B. Hadley; Ellsworth E. Hasbrouck, M.D.; William H. Hollweg; E. Duke McNeil; Jacob R. Suker, M.D.; Philip G. Thomsen, M.D. Executive Director: James G. Haughton, M.D.

Charting

Patient's departmental record will include:

1. Name, age, sex, race, religion.
2. Address and phone (if available).
3. Interested family--name, address, phone number
4. Patient's birth date.
5. Marital status
6. Children
7. Education
8. Work History
9. Avocational interests--if known
10. Source of payment
11. Diagnosis
12. Pertinent medical history and condition on admission.
13. Previous hospitalizations pertaining to current disease or disability.
14. Current medications.
15. Initial Evaluation (see below) and completed forms.
16. Weekly Progress Notes
17. Attendance Records
18. Monthly re-evaluation
19. Discharge Summary
20. Supervisor's Audit Record

Initial Evaluation will include: (To be placed in patient's medical chart with carbons in departmental chart)

1. Detailed results of definitive tests
2. General pictorial statement of patient's condition and needs.
3. Short-term goals aim of treatment and procedure
4. Long-term goals--aim of treatment and procedure
5. Approximate length of treatment
6. Highest level at which the therapist believes patient will be able to function.

Progress notes will include: (To be placed in patient's medical chart with carbon in department chart)

1. Number of treatment sessions covered by note with reason for absence, i.e., Mr. Jones attended three of five scheduled treatment sessions since 11/29/74. His absences were due to clinic visits.
2. General mood, cooperation, attitude, concentration span, complaints
3. Appearance of part/parts being treated, i.e. swelling, atrophy.
4. Reaction to pain, indicating severity, longevity, location, frequency, and precipitating factors.
5. What treatment patient has been receiving and how he has progressed. Indicate level of improvement using standard measurements and terms.
6. Note any change in treatment goals and/or methods of accomplishing those goals.

Oak Forest Hospital
Oak Forest, Illinois

Frequency and Sequence

1. Initial evaluation will be written both in Departmental and Medical Chart by third treatment session or a period of not more than five days from initial visit.

2. Weekly progress notes will be charted in both medical chart and patient's departmental chart.
   a. Rehabilitation Hospital Unit - Patients who are not currently being treated by Occupational Therapy will be briefly re-evaluated and a weekly summary note written.
   b. Restoration Gym and Ward Units - Patients on temporary hold, pass, etc. will require weekly progress notes stating why treatment was not given.

3. At least once a month a re-evaluation note must be written. It may be combined with the weekly progress note, but will clearly state that it is a re-evaluation.

   All points covered under the initial evaluation or last re-evaluation note are to be re-checked and the appropriate changes made. New goals, treatment aims and procedures will be stated.

4. Unit supervisors will run a weekly audit on at least two charts per team per week. Any problems, irregularities, or recurring negligence will be reported to the Director of Occupational Therapy and appropriate action will be taken.

Oak Forest Hospital
Oak Forest, Illinois

AUDIT

REVIEW DATE ______________________

THERAPIST's NAME ______________________

PATIENT's NAME ______________________

REFERRAL DATE ______________________

TREATMENT INITIATED ______________________

INITIAL NOTE (DATE) ______________________

WEEKLY NOTES (DATE) ______________________

MONTHLY RE-EVAL DATES ______________________

OCCUPATIONAL THERAPY CHART CONTENTS:

	ADEQUATE	COMMENTS
PATIENT INFORMATION (I,1-14)		
INITIAL EVALUATION (II,1-6)		
WEEKLY PROGRESS NOTES (III,1-6)		
DR's. ORDER AND RE-ORDER DATE		
ATTENDANCE RECORD		
TREATMENT PLAN (WITHIN INITIAL NOTE)		

METHODIST HOSPITAL
Occupational Therapy Department
Madison, Wisconsin

To: Arlynn Schenk and Judy Purtell (Council on Practice - W.O.T.A.)
Subject: O.T. Peer Review
Date: April 4, 1974

1. How the program was initiated:

The concept and word "peer review" has been talked of by members in the O.T. profession, as well as other professions for some time, however it was the A.O.T.A. Annual Conference in 1973 that provided us with the impetus to pursue a peer review process in our department. The session on "Competency - Its Threat and Strength" was extremely helpful in providing an example of an established structure which was being used to implement the peer review process.

2. What aspects of review are being considered:

Like University Hospital, Ann Arbor, Michigan, we too are using the written progress note as the criteria for peer review. We have found that the advantages of using this particular criteria are:

a) Written progress notes can be evaluated in a fairly objective manner once specific standards for content have been agreed upon.

b) There is a high correlation between written work and therapy performance. There have been a number of studies which substantiate this concept, however I cannot state any exact ones at present. In my own experience with therapists and students, I have certainly found this to be true. Once the therapist or student can state succinctly what her goals and rationale of treatment are, she can more easily work toward achieving them.

c) Often the primary means of communication with physicians and other staff, is through the patients' progress notes, so it would seem appropriate that the high standards of practice should be apparent in the therapist's progress notes. I personally feel also, that once the therapist or student can write well, with additional practice in speaking, her ability to orally express her goals, rationale of treatment, and general knowledge tends to improve.

d) By establishing standards of content for progress notes, one is, in effect, developing some consistency not only in individual therapists' notes, but also in methods of patient treatment.

3. Method of review:

Several sessions were spent in developing standards for O.T. progress notes, and this was done with total stuff participation. Each therapist's ideas were equally weighted with all other staff members, including the director. Once the standards were established, and all therapists felt that they could "live with" them, they were formulated into policy and approved by administration. Condensed check lists for evaluating psychiatric O.T. progress notes and physical disabilities-general medicine O.T. progress notes were drawn up into forms for use during the monthly peer review sessions.

Monthly peer review sessions are now conducted with all staff members present, as opposed to a peer review committee, since our staff is small (4 staff, 1-2 affiliates). Originally two discharged patients of each therapist were to be selected for review, however in our first two months, it has only been possible to review one note of each therapist. Each therapist reads her note, while other therapists take turns marking the peer review checklist forms, however all therapists have input as to whether the particular area of content is satisfactory or unsatisfactory.

4. Copies of forms being used: (see attached)

5. Reactions of reviewers & reviewees:

All therapists feel that peer review is beneficial in that notes are submitted on time consistently, and the standards provide a good structure of content. The psychiatric O.T. feels that the progress notes are longer than they were initially, however the content is relevant and important. The pressure of one's peers is probably much more effective than supervisory pressure to maintain high standards in this area.

Erica G. Hanson, O.T.R.
Director of Occupational Therapy

METHODIST HOSPITAL
Madison, Wisconsin

File: ____________________

Policy Supersedes: ________

POLICY

From: Occupational Therapy

Subject: STANDARDS FOR OT PROGRESS NOTES

Effective Date: January 1, 1974

OT Consultation Statement:

I. To be entered in medical chart of all hospital patients (except psychiatric patients) by the end of the second patient treatment. This note may be handwritten in the medical chart on the "O.T. Progress Note" form with a carbon copy retained in OT. (In psychiatry, the O.T. consultation statement and initial evaluation are combined.)

II. To include:

- A. Date referral received and treatment initiated.
- B. Correct referring physician (check in medical chart).
- C. Diagnosis or reason for hospital admission (see medical chart).
- D. Patient's age and sex.
- E. Reason for referral (in the general hospital only).
- F. Length and frequency of treatment.
- G. General OT goals with the patient.
- H. A final statement to the effect that more specific evaluative findings and subsequent notes will follow, when appropriate.

III. In addition, in all consultation notes, whenever appropriate include:

- A. Patient's initial attitude toward therapy.
- B. General functional or behaviorial observations.

IV. Consultation statements are not required for outpatients.

Initial Evaluation:

I. To be written on each inpatient and entered in the chart after 5 patient treatment days.

II. To be written on each new outpatient after 2 visits.

III. To include for:

A. General Medicine and Surgery and Physical Disabilities

1. Physical status - as appropriate.
    - a. Gross sensory
    - b. Range of motion
    - c. Manual muscle tests
    - d. Dynamometer and pinch-meter readings
    - e. Endurance

2. Activities of Daily Living (ADL) status - as appropriate.
    a. Sitting balance
    b. Degree of independence in dressing, feeding, hygiene, etc.
    c. Significant information regarding expectations of patient when he leaves the hospital, etc.
3. Homemaking or work status, and/or history as appropriate.

4. Emotional status:
    a. General attitude
    b. Attitude toward OT - motivation, cooperation, etc.
    c. Significant aspects of family and social history.

5. Activities used in treatment and rationale for their use.
6. Specific current OT goals
7. Projected OT goals - as appropriate
8. Precautions - as appropriate
9. Estimated length of treatment times for all outpatients and for inpatients as appropriate.

B. Psychiatric Unit Patients

1. All information necessary to include on OT consultation statements for general hospital patient (see page 1).
2. Marital status.
3. Social interactions with team and therapist.
4. Relevant findings or behaviors connected with the production of the initial collage.
5. Specific behaviorial assessment (i.e., attitude, affect, reality orientation, hypo- or hyper-activity, motivation, interest, dependence, assertiveness, aggressiveness, cooperation, self image).
6. Current emotional status.
7. Communication and socialization abilities.
8. Intellectual or cognitive level.
9. Response to OT tasks and program.
10. Response to therapist, staff, and peers.
11. Previous home and work situation and responsibilities, if known.
12. Interest/spare time activities.
13. Assessment of work behavior - skills.
14. Self care status or abilities - if appropriate.
15. Precautions - suicidal observation, elopement, pertinent medication side effects, appropriate use of dangerous tools or equipment.
16. Patient's goals.
17. Estimated length of treatment time for all outpatients.

__Interim Progress Notes:__

I. Inpatient notes are to be typed and entered in the patients medical chart every seven __calendar__ days following initial evaluation of patient. Outpatient notes for patients attending daily sessions should be entered every seven calendar days, for patients attending 3-4 days a week every 14 calendar days, and 1-2 days a week a minimum of every twenty-one calendar days.

II. Categorically, interim progress notes should include:

   A. Changes in patient program.
   B. Changes in OT goals or program.
   C. Media, equipment, evaluative tools and treatment techniques used.
   D. Frequency and length of treatment and changes in length or frequency of treatment sessions.
   E. Periodic statements about patient's attitude and behavior toward tasks, therapy, therapist, others.
   F. Periodic statements regarding patient's current emotional and/or functional status.
   G. Changes in ADL status - if appropriate (see initial evaluation)
   H. Psych only: Patient's approach and/or response to weekly group oriented activities as well as to individual OT projects.

III. Brief handwritten notes may be entered in the medical chart at anytime between weekly interim notes to document sudden change or problems which need to be brought to the doctor's and staff's immediate attention. A similar notation should then be made on the patient's OT Kardex card.

__Final Summary:__

I. To be written on any patient discontinued from or by OT.

II. To be written on any patient seen for 3 or more weeks in OT.

III. To include:

   A. Total length of treatment (with shorter term patients, the length of treatment time should appear in the last patient note.)
   B. Summarized result of treatment (comparison of pre and post treatment)
   C. Reasons for discontinuation.
   D. Recommendations for all functional patients and others as appropriate.

IV. If patient remains 2-3 days after summary has been completed, a brief handwritten note in OT file documenting subsequent treatment time is adequate. For longer periods of discharge delay, notes should continue to be entered in the medical chart.

Submitted by: ______________________ Approved: ______________________

______________________ WILLIAM E. JOHNSON, JR.
Administrator

METHODIST HOSPITAL
Madison, Wisconsin

O.T. PEER REVIEW OF PROGRESS NOTES - PSYCHIATRY

Therapist ____________________

Date ____________________

Pt. Name ____________________

Pt. Number ____________________

	Satis-factory	Unsatisfactory, reason
I. O.T. Consultation Statement and Initial Evaluation		
A. Date referral received and treatment initiated (after 5 treatment days).		
B. Correct referring physician.		
C. Diagnosis or reason for hospital admission.		
D. Patient's age and sex.		
E. Length and frequency of treatment.		
F. General O.T. goals with the patient.		
G. Marital status.		
H. Social interactions with team and therapist.		
I. Specific behavioral assessment (i.e., attitude, affect, reality orientation, interest, dependence).		
J. Current emotional status.		
K. Communication and socialization abilities.		
L. Intellectual or cognitive level.		
M. Response to OT tasks and program.		
N. Response to therapist, staff, and peers.		

	Satis-factory	Unsatisfactory, reason
O. Previous home and work situation and responsibilities.		
P. Interest / spare time activities.		
Q. Relevant findings or behaviors connected with the production of the initial collage.		
R. Assessment of work behavior skills.		
S. Self-care status or abilities - if appropriate.		
T. Precautions - suicidal observation, elopement, etc.		
II. Interim Progress Notes		
A. Entered every seven calendar days (for inpatients.		
B. Changes in patient program.		
C. Changes in OT goals or program.		
D. Media, equipment, evaluative tools, and treatment techniques used.		
E. Frequency and length of treatment and any changes in treatment sessions.		
F. Changes in patient's attitude, behavior toward tasks, therapy, therapist, others.		
G. Changes in emotional or functional status.		
H. Patient's approach and/or response to weekly group oriented activities as well as to individual OT projects.		
III. Final Summary		
A. Discontinued or discharged (after 3 or more weeks in OT).		
B. Total length of treatment.		

	Satisfactory	Unsatisfactory, reason
C. Summarized results of treatment.		
D. Reasons for discontinuation.		
E. Recommendations, if appropriate.		
F. Attendance.		
G. Discharge destination.		

METHODIST HOSPITAL
Madison, Wisconsin

O.T. PEER REVIEW OF PROGRESS NOTES - PHYSICAL DISABILITIES, GENERAL MEDICINE

Therapist ____________________

Date ____________________

Pt. Name ____________________

Pt. Number ____________________

	Satisfactory	Unsatisfactory, reason
I. O.T. Consultation Statement		
A. Date referral received and treatment initiated (within 2 days)		
B. Correct referring physician		
C. Diagnosis or reason for hospitalization.		
D. Patient's age and sex.		
E. Reason for referral.		
F. Length and frequency of treatment.		
G. General O.T. goals for patient.		
II. Initial Evaluation		
A. Date entered (after 5 treatment days).		
B. Physical status as appropriate, gross sensory, ROM, muscle tests, dynamometer, endurance, etc.		
C. ADL - as appropriate, sitting balance, level of independence (current and expected).		
D. Homemaking, vocational status as appropriate.		
E. Emotional status - general attitude, motivation in O.T., significant social history, etc.		

	Satis-factory	Unsatisfactory, reason
F. Activities used and rationale.		
G. O.T. goals - current and projected (as appropriate)		
H. Precautions (as appropriate).		
I. Estimated length of treatment times for all outpatients and inpatients, as appropriate.		
III. Interim Progress Notes		
A. Entered every 7 days (for inpatients)		
B. Changes in goals		
C. Changes in frequency or length of sessions.		
D. Changes in emotional or functional status.		
IV. Final Summary		
A. Discontinued, or discharged (after 3 or more weeks of O.T.)		
B. Total length of treatment.		
C. Summarized results of treatment		
D. Reasons for discontinuation		
E. Recommendations for functional patients, and others, as appropriate.		
F. Discharge destination		

METHODIST HOSPITAL
Madison, Wisconsin

File: O.T. 6

POLICY

Policy Supersedes _______

Subject: PEER REVIEW
Effective Date: March 1974

PEER REVIEW:

Policy: The OT department staff will regularly participate in a peer review of departmental patient progress notes.

Purpose: To insure full documentation of OT services as outlined in OT progress note standards and to encourage the highest level of goal oriented patient treatment possible.

Procedure: Beginning February 1, 1974 a monthly random selection of two discharged patients per therapist or affiliating student from the previous month will be made for the purposes of peer review. All notes for each patient selected will then be reviewed by the entire staff and affiliating students according to the progress note standards criteria. Notes will be judged either satisfactory or unsatisfactory for each of the criteria. Unsatisfactory decisions should be accompanied by the reasons for that decision. Any therapist or student who does not satisfactorily meet all criteria will then be expected to improve her notes prior to the next months peer review session.

Submitted by: ______________________________
Erica Hanson
Director, Occupational Therapy

Approved: ______________________________
WILLIAM E. JOHNSON, JR.
Administrator

4 February 75

American Occupational Therapy Association
PER Division
6000 Executive Blvd.
Rockville, Md. 20852

Inclosed are copies of the standards and guidelines for peer review at Walter Reed Army Medical Center. The standards apply only to the OT clinical record and outlines the information that should be documented in the records. We are in the process of developing standards for the quality of information reflected in the records and the care provided to the patient. We use the occupational behavior frame of reference for OT treatment and the problem oriented approach to planning and reporting treatment programs.

If additional information is needed please contact -

ELOISE B STRAND
OSC Box 596
Walter Reed Army Medical Center
Washington, D. C. 20012

Department of the Army
Occupational Therapy Section
Physical Medicine Service
Walter Reed Army Medical Center
Washington, DC 20012

STANDARDS FOR PEER REVIEW
OCCUPATIONAL THERAPY SECTION

	YES	NO	COMMENTS
1. Initial Assessment will include:			
A. Client ID Data			
B. Medical Data			
C. Psycho-Social Data			
1. Educational background			
2. Vocational History and Work Plans			
3. Leisure Activities and Play Skills			
4. Future Goals			
D. Functional Self-Care			
E. Attitude Toward Illness, Hospitalization, Rehabilitation, Discharge.			
F. Family Data			
G. Screening/Observation Data			
II. Treatment Program Reports			
A. Problem List			
B. Short/Long Term Goals			
C. Program Methods			
D. Estimated Length of OT Services			
E. Response to Initial Consult or Initial Contact - 5 working days.			
F. Results and Revisions			
1. Notes in OT chart, once per week			
2. Progress notes, ward chart, once a month or as appropriate.			
G. Discontinuation and Discharge Summary - Completed within two working days			

Walter Reed Army Medical Center
Occupational Therapy Clinic
January 1974

Therapist ____________________

Patient ____________________

Chairpersons Initials __________

Peer Review Committee
GUIDELINES

1. Each clinics records will be reviewed once each month, with two records per therapist reviewed each month.

2. Committee will keeep a continuous record, by name of therapist and patient , of all records reviewed and deficient records found (if any).

3. Report of findsings will be given to therapists concerned.

4. All deficient records will be resubmitted at the next committee meeting. (Even if patient has been discharged)

5. Therapists who have three deficient charts (including repetitions) in a row will be contacted by the committee member from that clinic to point out problem areas.

6. Therapists who have five deficient charts will have their supervisor advised of same.

7. Review committee will also pull two discharged records each time to review the complete record, to include discharge summary.

8. The member who is on the committee for the third month will be Committee Chairperson adn responsible for all committee functions.

ROTATING SCHEDULE

Term Ends	Date	Term Begins
CPT Sinnott	15 January	MAJ Baker
CPT Livingston	15 February	SSG Nurse
Ms Hiranaka	15 March	LTC Strand
MAJ Baker	15 April	SSG Tortorete
SSG Nurse	15 May	1LT Swan
LTC Strand	15 June	Sp4 Harvey

Alternates
1. Sp4 Roman
2. Sp4 Dudnick

Walter Reed Army Medical Center
Occupational Therapy Section
January 1975

DIVISION OF OCCUPATIONAL THERAPY
DEPARTMENT OF PHYSICAL MEDICINE AND REHABILITATION
UNIVERSITY HOSPITAL, ANN ARBOR, MICHIGAN

PEER REVIEW

Objective

A peer review committee will be established to review written notes in order to assess the effectiveness of O.T. services, to assist the professional development of staff, and to improve the quality of patient care and written work.

I. Peer Review Committee
- The peer review committee will consist of a chairman and 4 committee members.
- The chairman will be elected by the staff (OTR, OTA) and will not serve more than one term.
- The committee will consist of one supervising therapist, two staff and one assistant. The committee will be randomly drawn from a list of people in the three job classifications. No committee member will serve more than one term.
- A limited number of observers may request to sit in on reviews.

II. Term of Reviewers and Chairman
- A new peer review committee will be chosen every 6 months.
- Previous chairman will attend the first meeting of incoming committee members to answer questions and give the group directions.

III. Procedures
- The peer review committee will meet 12 times per year on a monthly basis.
- The names of the registered therapists will be placed in alphabetical order and divided in half to form two groups. These two groups of names will be alternated each month to insure the opportunity for each registered therapist to have 6 discharged patient occupational therapy records reviewed per year.
- Section of the O.T. records to be reviewed will be on a random basis. (See chairman's responsibilities for method.)
- It will be each registered therapist' responsibility to insure that the notes of the students and assistants whom she supervises are in accord with the policies and procedures of the Occupational Therapy Department.

IV. Chairman's Responsibilities
- Chairman will submit to the secretary the list of therapists to be reviewed 4 days prior to the review meeting. Accompanied with this list will be a random number after each name; for example, Doe #4. For each therapist who is to be reviewed, the secretary will use the random number to pick the corresponding number on the therapist's list of patients who were discharged the prior month.
- Chairman will also request that the secretary call the medical records and pull the O.T. files of the randomly selected patients.
- Chairman will lead the review meeting. Chairman will appoint a committee member to record reviews and to submit to the Chief of the Occupational Therapy Department a report of who was present at the review meeting and how many reports were reviewed and which therapists' reports.
- Upon completion of the peer review meeting the chairman will request that the completed peer review form be initialed by all reviewers and be photocopied by the secretary. The chairman will give the original copy of the peer review form to the therapists reviewed and place the copy in the peer review statistical notebook.
- Chairman will insure that medical records and O.T. files are returned to their appropriate place.

DIVISION OF OCCUPATIONAL THERAPY
DEPARTMENT OF PHYSICAL MEDICINE AND REHABILITATION
UNIVERSITY HOSPITAL, ANN ARBOR, MICHIGAN

THERAPIST'S NAME ____________________

DATE ____________________

PATIENT'S NAME ____________________

REGISTRATION NUMBER ____________________

STANDARDS REVIEWED FOR NOTE WRITING

		SATISFACTORY	UNSATISFACTORY MUST INCLUDE COMMENTS	COMMENTS
1.	Referrals:			
a.	received from a physician (special registration patients excluded)			
b.	answered within 48 hours for staff			
c.	answered within 72 hours for affiliates			
d.	initial interview was performed and recorded within 48 hours for staff or 72 hours for affiliates			
2.	Reports:			
a.	submitted 7 calendar days after initial evaluation and every 7 days following unless patient temporary discontinued			
b.	indicated changes in program			
c.	included equipment, evaluation tools, treatment techniques used			
d.	included frequency and length of treatment			
e.	included statements about patient's attitude			
3.	Written Work Indicated One or More of the Following:			
a.	interaction with family			
b.	home visit was made			
c.	interaction with community			
d.	interaction with other staff			
e.	follow up contact			
f.	written home program			
g.	no further contact			
4.	Discharge or Discontinuation Report:			
a.	submitted 7 calendar days after date of discharge or discontinuation from program			
b.	included total length of treatment			
c.	summarized result of treatment (comparison of pre and post treatment)			
d.	reasons for discontinuation			
e.	recommendations			

SECTION C

BIBLIOGRAPHY

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APPENDIX VIII

Sample Data Abstract Form used in Chart Audit Study

OCCUPATIONAL THERAPY DATA ABSTRACT FORM FOR RECORD REVIEW

MINIMAL STANDARDS OF PRACTICE FOR OCCUPATIONAL THERAPY FOR STROKE PATIENTS*

I. EVALUATION STANDARDS

The occupational therapist clearly and specifically documented the findings of the initial and final occupational therapy evaluation which included consideration and/or assessment of the patient's goals, assets and limitations in:

A. Performance of activities of daily living *(see glossary)

1. self-care skills
2. work skills and/or potential
3. other daily living skills

B. The following performance components:

1. bilateral muscle strength and/or control
2. bilateral muscle tone
3. bilateral range of motion
4. bilateral patterns of movement
5. bilateral dexterity and/or coordination
6. bilateral sensation
7. cognitive function
8. visual field
9. sensory-integration

C. The anticipated discharge environment:

1. physical environment
2. social support structure
3. attitude, goals, and capabilities of significant others

	Initial Evaluation		Final Evaluation		If the standard was not met; what was the justification?		Indicate with a yes or no whether the standard is:				
	Standard Met	Standard Not Met	Standard Met	Standard Not Met			Accurate	Achievable	Measurable	Understandable	Realistic
1						1					
2						2					
3						3					
1						1					
2						2					
3						3					
4						4					
5						5					
6						6					
7						7					
8						8					
9						9					
1						1					
2						2					
3						3					

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* These standards have been prepared by a task force of occupational therapists working under the auspices of the AOTA-HEW Continuing Competency Contract (NO1-AH-44116). The standards of practice stated here are not finalized and are not official.

November 1975

I. EVALUATION STANDARDS (Cont'd)

D. Other factors:

1. age
2. economic status
3. educational background
4. socio-cultural background
5. psychological status
6. related medical problems and precautions

	Initial Evaluation		Final Evaluation		If the standard was not met; what was the justification?		Indicate with a yes or no whether the standard is:				
	Standard Met	Standard Not Met	Standard Met	Standard Not Met			Accurate	Achievable	Measurable	Understandable	Realistic
1						1					
2						2					
3						3					
4						4					
5						5					
6						6					

II. TREATMENT PLANNING AND IMPLEMENTATION STANDARDS

A. A treatment plan was formulated and documented for the purpose of attaining and maintaining the client's optimal level of function in activities of daily living.

The documented treatment plan clearly and specifically:

1. stated short- and long-term goals which reflect the expected overall results of treatment.
2. stated methods selected to achieve the goals

B. The treatment plan goals and methods were consistent with the evaluation findings and the goals of the patient and significant others.

C. When decreased ability to perform activities of daily living was a problem, the O.T. treatment plan included a goal of increasing ability to perform activities of daily living.

Methods used to increase ability included any or all of the following:

1. treating specific performance components that interfere with function
2. repetitive practice of activities of daily living
3. teaching one-handed methods for performance of activities of daily living
4. providing and training in the use of assistive devices
5. developing pre-vocational or avocational interests
6. giving recommendations to eliminate and/or adapt architectural or environmental barriers to performance in the discharge setting

					Indicate with a yes or no whether the standard is:				
	Standard Met	Standard Not Met	If the standard was not met; what was the justification?		Accurate	Achievable	Measurable	Understandable	Realistic
1				1					
2				2					
				1					
				2					
				3					
				4					
				5					
				6					

II. TREATMENT PLANNING AND IMPLEMENTATION STANDARDS (Cont'd)

	Standard Met	Standard Not Met	If the standard was not met; what was the justification?	Indicate with a yes or no whether the standard is:				
				Accurate	Achievable	Measurable	Understandable	Realistic
D. When muscle weakness and/or limited endurance was a problem where patient has isolated muscle control, the O.T. treatment plan included a goal of strengthening.								
Methods included any or all of the following:								
1. graded activity program								
2. assistive to active to resistive exercise program								
3. activities of daily living training program								
E. When limited passive joint range of motion was a problem, the O.T. treatment plan included a goal of preventing loss of and/or increasing passive range of motion.								
Methods included any or all of the following:								
1. teaching self-range of motion								
2. using exercise devices (pulleys, skateboard, etc.)								
3. using positioning devices (splints, slings, pillow, arm rests, lapboards, etc.)								
4. using graded activity programs								
5. performing passive range of motion or teaching significant others to do so								

II. TREATMENT PLANNING AND IMPLEMENTATION STANDARDS (Cont'd)

				Indicate with ✓ yes or no whether the standard is:				
	Standard Met	Standard Not Met	If the standard was not met; what was the justification?	Accurate	Achievable	Measurable	Understandable	Realistic
F. When lack of active motion in the involved extremity was a problem, the O.T. treatment plan included a goal of preventing loss of passive range of motion.								
1. If patient was seen within six months of onset, the goal also included encouraging active motion through the use of any methods which facilitate motion.								
2. Continued use of these methods was based upon measurable change in functional ability.								
G. When abnormal muscle tone was a problem, the O.T. treatment plan included a goal of preventing loss of passive range of motion.								
Methods included any or all of the following:								
1. methods which either facilitate or inhibit tone.			1					
2. passive range of motion			2					
3. referral to physician for medical management			3					
H. When abnormal patterns of movement (synergies) were a problem, the O.T. treatment plan included a goal of increasing motor control of the involved extremity.								
1. The plan included the use of methods to work through abnormal and facilitate normal patterns of movement.								
2. The continued use of methods to increase motor control was based on measurable change in the function.								

II. TREATMENT PLANNING AND IMPLEMENTATION STANDARDS (Cont'd)

	Standard Met	Standard Not Met	If the standard was not met; what was the justification?	Indicate with a yes or no whether the standard is:				
				Accurate	Achievable	Measurable	Understandable	Realistic
I. When lack of dexterity and/or coordination were problems, the O.T. treatment plan included goal of increasing dexterity and/or coordination through repetitive use of graded activities or exercise.								
J. When impaired sensation was a problem, the O.T. treatment plan included a goal of compensation for sensory impairment. Methods are specified.								
K. When confusion, disorientation, and/or poor judgment were problems, the O.T. treatment plan included a goal of decreasing confusion, and/or improving orientation and judgment.								
Methods used included any or all of the following:								
1. using reality orientation techniques			1					
2. structuring patient's daily activities or environment			2					
3. instructing significant others on approaches for patient management			3					
4. referral for medical management			4					
5. using sensory integrative techniques to increase orientation to the environment			5					

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II. TREATMENT PLANNING AND IMPLEMENTATION STANDARDS (Cont'd)

L. When impaired head or trunk control was a problem, the O.T. treatment plan included goals of improving head or trunk control and preventing injury.

Methods included any or all of the following:

1. the use of strengthening activities when weakness was identified as the cause
2. the use of exercises/activities to enhance posutral and quilibrium reactions and to increase awareness of bodv in space
3. the intermittent use of equipment to challenge control
4. provision of support equipment as needed
5. teaching the patient and/or significant others safety precautions

M. When neglect of the involved side was a problem, the O.T. treatment plan included goals of increasing awareness of the involved side of the body and preventing injury.

Methods included any or all of the following:

1. sensory stimulation
2. cognitive input
3. bilateral activities, especially those requiring crossing into neglected spaces
4. positioning of body parts where they can be more easily seen and less easily ignored
5. instructing significant others in the nature of the problem and safety precautions necessary

Standard Met	Standard Not Met	If the standard was not met; what was the justification?		Indicate with a yes or no whether the standard is: Accurate	Achievable	Measurable	Understandable	Realistic
			1					
			2					
			3					
			4					
			5					
			1					
			2					
			3					
			4					
			5					

II. TREATMENT PLANNING AND IMPLEMENTATION STANDARDS (Cont'd)

N. When depression and/or low self-esteem was a problem, the O.T. treatment plan included goals of improving self-esteem and alleviating depression.

Methods included any or all of the following:

1. encouraging and providing opportunity for the expression of feelings
2. involving the patient in success experiences
3. helping patient recognize his/her attributes
4. referral for medical or psychological management

O. When pain was a problem, the therapist notified the physician. The O.T. treatment plan included goal of decreasing pain if any of the following were causes:

	Cause	Minimal Treatment
1.	increased muscle tone	techniques to decrease tone
2.	unsupported joint	provide support
3.	joint tightness	range of motion
4.	edema	positioning, active exercise and/or providing support

P. When ability to communicate basic needs was a problem, the O.T. explored alternate methods of communication.

	Standard Met	Standard Not Met	If the standard was not met; what was the justification?	Indicate with a yes or no whether the standard is: Accurate	Achievable	Measurable	Understandable	Realistic
N								
1								
2								
3								
4								
O								
1								
2								
3								
4								
P								

	Standard Met	Standard Not Met	If the standard was not met, what was the justification?	Indicate with a yes or no whether the standard is:				
II. TREATMENT PLANNING AND IMPLEMENTATION STANDARDS (Cont'd)				Accurate	Achievable	Measurable	Understandable	Realistic
Q. When edema of the hand was a problem, the O.T. treatment plan included a goal of decreasing edema								
Methods used included any or all of the following:								
1. elevation of the hand			1					
2. application of pressure wrap			2					
3. referral for medical management			3					
R. When visual field deficit was a problem, the O.T. treatment plan included a goal of compensation for visual field deficit.								
Methods used included any or all of the following:								
1. teaching patient to scan			1					
2. increasing cognitive awareness of the problem			2					
3. using activities that require working in the impaired visual field			3					
4. instructing significant others on management of the problem			4					

II. TREATMENT PLANNING AND IMPLEMENTATION STANDARDS (Cont'd)

	Standard Met	Standard Not Met	If the standard was not met; what was the justification?	Indicate with a yes or no whether the standard is: Accurate	Achievable	Measurable	Understandable	Realistic
S. When apraxia was a problem that limited the ability to use or manipulate objects appropriately for function, the O.T. treatment plan included a goal of improving function.								
Methods used included any or all of the following:								
1. activity programs graded by cognitive requirements			1					
2. repetitive practice of similar motor acts using different objects			2					
3. graded, repetitive, manual guidance for handling and use of familiar objects			3					
4. increasing the complexity of functional performance as simpler tasks are mastered			4					
5. sensory-integrative techniques			5					

III. PROGRESS REPORT STANDARDS

	Standard Met	Standard Not Met	If the standard was not met; what was the justification?	Accurate	Achievable	Measurable	Understandable	Realistic
A. The type and amount of treatment patient has received was clearly and specifically stated at appropriate time intervals.								
B. The patient's progress/lack of progress was clearly and specifically stated at appropriate time intervals.								
C. The progress reports states the changes that were made in goals and methods as the patient's abilities changed.								

	Standard Met	Standard Not Met	If the standard was not met; what was the justification ?	Indicate with a yes or no whether the standard is:				
				Accurate	Achievable	Measurable	Understandable	Realistic
IV. DISCHARGE PLANNING STANDARDS								
A. Prior to discharge, the O.T. developed and documented a plan to assure maintenance or improvement of functional status of patient.								
The plan was based on previously acquired information about the discharge setting and included any or all of the following:								
1. home program			1					
2. out-patient treatment			2					
3. referral to appropriate home health agents (e.g., VNA, speech pathologist, P.T.s, other O.T.s)			3					
4. referral to community agencies (e.g., vocational rehabilitation services, rehabilitation centers, senior citizens' groups, religious organizations, social clubs)			4					
5. periodic reevaluation as outpatient			5					
V. DISCONTINUATION OF TREATMENT STANDARDS								
A. O.T. program was discontinued when the patient no longer benefited from treatment.								
B. The therapist documented:								
1. the patient's functional level			1					
2. the goals attained or reasons not attained			2					
3. the reason for discontinuation			3					

Reviewers Signature ______________________

APPENDIX IX

1. Standards of Job Performance in the Five Speciality Areas:
    - Mental Health
    - Developmental Disabilities
    - Physical Disabilities
        - Stroke
        - Arthritis

2. AOTA Statement on "Occupational Therapy Referral" (1969)

3. Glossary of Terms

Prepared under the auspices of the AOTA Continuing Competency Project
Contract No. NOI-AH-44116.

January 1976

Standards of Practice for Occupational Therapy Services

In a Mental Health Program[1]

A. Referral Standards[2]

1. If a referral is received, the therapist shall:

   a. document the date of receipt and referral source
   b. document the occupational therapy services requested in the referral

B. Evaluation Standards[3]

1. The therapist shall evaluate and document the client's goals, functional abilities and deficits in occupational performance (activities of daily living):

   a. self-care skills
   b. work skills
   c. play/leisure skills

2. The therapist shall evaluate and document the client's goals, functional abilities and deficits in the following performance component areas:

   a. psychological/intrapersonal skills
   b. social/interpersonal skills
   c. cognitive skills

3. If the results of the occupational performance evaluation indicate possible deficits in the client's motor and/or sensory-integrative skills, the therapist should evaluate these areas and document any functional deficits; or should refer the client to another practitioner for evaluation.

---

1) These standards have been developed by occupational therapists working under the auspices of the AOTA Continuing Certification Program and the AOTA-HEW Continuing Competency Contract No. NO1-AH-44116. These standards are available for use in a self-assessment or peer review program; however, they are not official AOTA standards until approved by the AOTA Delegate Assembly. Any questions regarding their use should be directed to the AOTA Director of Certification.
2) Refer to the attached AOTA "Statement on Occupational Therapy Referral," for guidelines regarding referral for occupational therapy service.
3) Refer to the attached glossary for definitions of terms.
4) The standards are not PSRO screening criteria. AOTA model screening criteria are available for $2.00 from AOTA, Practice Division.

(January 1976 Edition)

4. If any of the above evaluation results indicate the client's need for referral to community services or programs, the therapist should determine the availability of such community resources; or should refer the evaluation to another practitioner.

C. Program Plan Standards

1. The therapist shall prepare and document a program plan based upon an analysis of:

    a. the occupational therapy evaluation data
    b. the client's expected prognosis

2. The documented program plan shall consist of a statement of achievable program goals and the methods to achieve the goals.

3. The program plan goals and methods shall be consistent with the evaluation data on the client's goals, functional abilities and deficits, community resources, and expected prognosis.

4. The program plan goals and methods shall be compatible with the program plans of the other health care practitioners.

D. Program Implementation Standards

1. The therapist shall implement the occupational therapy program according to the program plan.

2. The therapist shall periodically document the occupational therapy services provided and the frequency of the services.

3. The therapist shall periodically re-evaluate and document the changes in the client's occupational performance and performance component skills.

4. The therapist shall formulate, document and implement program changes consistent with changes in the client's occupational performance and performance component skills.

E. Discharge Standards

1. The therapist shall prepare and document the occupational therapy discharge plan.

2. The discharge plan shall be consistent with the client's goals, functional abilities and deficits, community resources, and expected prognosis.

3. The discharge plan shall be consistent with the discharge plans of the other health care practitioners.

4. Sufficient time should be allowed for coordination, acceptance and effective implementation of the discharge plan.

5. The therapist shall document the client's functional abilities and deficits in occupational performance and performance component skills at time of discharge.

6. The therapist shall terminate occupational therapy services when the client has achieved the goals; or when the client has achieved maximum benefit from occupational therapy.

F. Follow-up Standards

For clients with chronic condition:

1. The therapist shall re-evaluate the client at an appropriate time interval following discharge.

2. The re-evaluation results shall be documented.

3. If the client needs further service, the therapist shall refer the client to the services needed.

January 1976

Standards of Practice for Occupational Therapy Services for the Developmentally Disabled Client[1]

A. Referral Standards[2, 3]

1. A client should be referred to the occupational therapist for evaluation when the client has or appears to have a dysfunction in any of the following areas:

   a) occupational performance (activities of daily living):
      1) self-care activities
      2) home-work-school activities
      3) play/leisure activities

   b) performance components:
      1) neuromuscular development
      2) sensory-integrative development
      3) psychological development
      4) social development
      5) cognitive development

2. If a referral is received, the therapist shall document:

   a) the date of receipt and referral source
   b) services requested in the referral

---

[1] These standards have been developed by occupational therapists working under the auspices of the AOTA Continuing Certification Program and the AOTA-HEW Continuing Competency Contract No. NO1-AH-44116. These standards are available for use in a self-assessment or peer review program; however, they are not official AOTA standards until approved by the AOTA Delegate Assembly. Any questions regarding their use should be directed to the AOTA Director of Certification.

[2] Refer to the attached AOTA "Statement on Occupational Therapy Referral," for guidelines regarding referral for occupational therapy service.

[3] Refer to the attached glossary for definitions of terms.

[4] The standards are not PSRO screening criteria. AOTA model screening criteria are available for $2.00 from AOTA, Practice Division.

(January 1976 Edition)

B. Evaluation Standards

1. The occupational therapy evaluation shall include an assessment of the developmental level, as well as the functional abilities and deficits in the following areas:

   a) occupational performance (activities of daily living):
      1) self-care skills
      2) home-work-school skills
      3) play/leisure skills

   b) motor skills

   c) sensory-integrative skills

2. If the results of the above evaluation indicate possible deficits in psychological/social and/or cognitive skills, the therapist should evaluate these areas and document any functional deficits; or should refer the client to the appropriate service/individual.

3. If any of the above evaluation results indicate the client's need for referral to community services or programs, the therapist should determine the availability of such community resources; or should refer the evaluation to the appropriate service/individual.

4. All evaluation methods shall be appropriate to the chronological age and functional level of the client. The methods may include, but need not be limited to, observation of activity performance, interview, record review and testing.

5. If standardized evaluative tests are used, the tests should have normative data for the age range of the client. If normative data are not available for the age range of the client, the standardized test results should be expressed in relation to the normative data that are available.

6. The therapist shall document the evaluation results in the client's record.

C. Program Plan Standards

1. The therapist shall prepare and document a program plan based upon an analysis of:

   a) the occupational therapy evaluation data
   b) the client's expected prognosis

2. The documented program plan shall consist of a statement of achievable program goals and the methods to achieve the goals.

3. The program plan goals and methods shall be consistent with:

   a) established principles of normal growth and development
   b) the evaluative results and expected prognosis
   c) the goals of the client's family and significant others
   d) the program plans of the other health care practitioners

4. When the occupational therapy program goal is to prevent or diminish dysfunction in occupational performance (activities of daily living) or to enhance occupational performance, the program plan shall include the use of one or more of the following types of activities:

   a) self-care activities; may also include instruction in the use of adapted methods and/or equipment
   b) home-work-school activities; may also include instruction in the use of adapted methods and/or equipment
   c) play/leisure activities; may also include instruction of family in play activities appropriate for child's developmental level; instruction in in the use of adapted methods and/or equipment

5. When the goal is to prevent or diminish neuromuscular dysfunction or enhance neuromuscular development, the program plan shall include (but need not be limited to) the use of one or more of the following types of activities:

   a) activities which maintain or increase range of motion and/or muscle strength
   b) activities which facilitate integration of developmentally appropriate reflex behavior
   c) activities which provide sensory stimulation
   d) activities which promote the development of normal movement patterns and motor control
   e) activities which maintain or increase coordination
   f) instruction in use of proper positioning techniques
   g) provision of and instruction in the use of adaptive equipment and/or orthotic devices

6. When the goal is to prevent or diminish sensory-integrative dysfunction or to enhance sensory-integrative development, the program plan shall include (but need not be limited to) the appropriate use of one or more of the following techniques:

   a) sensory stimulation techniques for visual, auditory, gustatory, olfactory, tactile, proprioceptive, kinesthetic, and/or vestibular stimulation
   b) facilitation techniques
   c) inhibition techniques

7. When the goal is to prevent or diminish psychological dysfunction or to enhance psychological development, the program plan shall include (but need not be limited to) the use of activities which assist the client in learning to:

   a) experience and cope with competition, frustration, success, failure; and/or
   b) express feelings; and/or
   c) develop self esteem; self identity;

8. When the goal is to prevent or diminish social dysfunction or to enhance social development, the program plan shall include (but need not be limited to) the use of activities which assist the client in learning to:

   a) imitate and develop appropriate social behavior; and/or
   b) listen and communicate; and/or
   c) develop sensitivity to other persons feelings and behavior;

9. When the goal is to prevent or diminish cognitive dysfunction or to enhance cognitive development, the program plan shall include (need need not be limited to) the use of the following activities which assist the client in developing:

   a) concentration/attention span; and/or
   b) memory/recall; and/or
   c) decision making and problem solving skills

D. Program Implementation Standards

1. The therapist shall implement the program according to the program plan.

2. The therapist shall periodically document the occupational therapy services provided and the frequency of the services.

3. The therapist shall periodically re-evaluate and document the changes in the client's occupational performance and performance component skills.

4. The therapist shall formulate, document and implement program changes consistent with changes in the client's occupational performance and performance component skills.

E. Discharge Standards

1. The therapist shall prepare and document the occupational therapy discharge plan.

2. The discharge plan shall be consistent with the client's goals, functional abilities and deficits, community resources, and expected prognosis.

3. The discharge plan shall be consistent with the discharge plans of the other health care practitioners.

4. Sufficient time should be allowed for coordination, acceptance and effective implementation of the discharge plan.

5. The therapist shall document the client's functional abilities and deficits in occupational performance and performance component skills at time of discharge.

6. The therapist shall terminate occupational therapy services when the client has achieved the goals; or when the client has achieved maximum benefit from occupational therapy.

January 1976

Standards of Practice for Occupational Therapy Services for Clients with Physical Disabilities[1]

A. Referral Standards[2]

1. If a referral is received, the therapist shall document:

   a. the date of receipt and referral source
   b. the services requested
   c. the above (a&b) within one working day of the receipt of the referral

B. Evaluation Standards

1. The therapist shall orient the client, family and/or significant others to the purposes and procedures of the occupational therapy evaluation.

2. An initial evaluation shall be completed and the results documented within at least five working days after acknowledgement of referral receipt.

3. The initial evaluation shall include an initital assessment of the client's goals, and functional abilities and deficits in:

   a. self-care skills
   b. work skills
   c. play/leisure skills

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1) These standards have been developed by occupational therapists working under the auspices of the AOTA Continuing Certification Program and the AOTA-HEW Continuing Competency Contract No. NO1-AH-44116. These standards are available for use in a self-assessment or peer review program; however, they are not official AOTA standards until approved by the AOTA Delegate Assembly. Any questions regarding their use should be directed to the AOTA Director of Certification.
2) Refer to the attached AOTA "Statement on Occupational Therapy Referral," for guidelines regarding referral for occupational therapy service.
3) Refer to the attached glossary for definitions of terms.
4) The standards are not PSRO screening criteria. AOTA model screening criteria are available for $2.00 from AOTA, Practice Division.

(January 1976 Edition)

4. The evaluation should also include an assessment of the client's functional abilities and deficits in:
    a. motor skills

5. If any of the above (items 3 and 4) evaluation results indicate possible deficits in:
    a. sensory-integrative skills
    b. psychological skills
    c. social skills, and/or
    d. cognitive skills,

    the therapist should evaluate these areas and document any functional deficits; or should refer the client to the appropriate service/individual for evaluation.

6. If any of the above evaluation results indicate the client's need for referral to community services or programs, the therapist should determine the availability of such community resources; or should refer the evaluation to the appropriate service/individual.

7. The therapist should obtain information about the client's medical history, education, work history, avocational interests, family, and cultural background. This information may be obtained through client interview, record review, and/or discussion with informed sources.

C. Program Plan Standards

1. The therapist shall prepare and document a program plan based on an analysis of:
    a. the occupational therapy evaluation data
    b. the client's expected prognosis

2. The therapist shall document the program plan within six working days after the acknowledgement of the referral receipt.

3. The documented program plan should consist of a statement of:
    a. achievable program goals
    b. methods to achieve the goals

4. The program plan goals and methods should be consistent with:
    a. the evaluative results and expected prognosis
    b. the goals of the client and/or family
    c. the program plans of other health care practitioners

5. The program plan methods may include, but need not be limited to, the use of:
    a. adaptive equipment and techniques
    b. assistive, active and/or resistive activities and exercises

c. counseling techniques
d. facilitation/inhibition techniques
e. joint protection techniques
f. orthotic and/or prosthetic devices
g. work simplification techniques

D. Program Implementation Standards

1. The therapist shall implement the occupational therapy program according to the program plan.

2. The therapist shall document at least every five working days, the occupational therapy services provided, the frequency of the services, and the client's progress toward goals.

3. The therapist shall periodically re-evaluate and document the changes in the client's occupational performance and/or performance component skills.
   a. if the client's program exceeds a 3-month period, the client should be re-evaluated at least every two months.
   b. if the client's program is less than three months, the client should be re-evaluated at least once per month.

4. The therapist shall formulate, document and implement program changes consistent with the changes in the client's occupational performance and performance-component-skills.

E. Discharge Standards

1. The therapist shall prepare and document the occupational therapy discharge plan.

2. The discharge plan shall be consistent with the client's goals, functional abilities and deficits, community resources, and expected prognosis.

3. The discharge plan should be consistent with the discharge plans of the other health care practitioners.

4. In the preparation of the discharge plan, the therapist should allow enough time for coordination, acceptance, and effective implementation of the discharge plan.

5. The therapist shall document within two days following discharge, the client's functional abilities and deficits in occupational performance and performance component skills at the time of discharge.

6. The therapist shall recommend discontinuation of occupational therapy services when the client has achieved the program goals and/or has achieved maximum benefit from the services.

Standards of Practice for Occupational Therapy Services for Stroke Patients[1]

A. Referral Standards[2]

1. If a referral is received, the therapist shall document:

   a. the date of receipt and referral source
   b. the services requested
   c. the above (a&b) within one working day of the receipt of the referral

B. Evaluation Standards[3]

1. The therapist shall orient the client, family and/or significant others to the purposes and procedures of the occupational therapy evaluation.

2. An initial evaluation shall be completed and the results documented within at least five working days after acknowledgement of referral receipt.

3. The initial evaluation shall include an initial assessment of the client's goals, and functional abilities and deficits in:

   a. occupational performance (activities of daily living):
      1) self-care skills
      2) work skills
      3) play/leisure skills

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1) These standards have been developed by occupational therapists working under the auspices of the AOTA Continuing Certification Program and the AOTA-HEW Continuing Competency Contract No. NO1-AH-44116. These standards are available for use in a self-assessment or peer review program; however, they are not official AOTA standards until approved by the AOTA Delegate Assembly. Any questions regarding their use should be directed to the AOTA Director of Certification.
2) Refer to the attached AOTA "Statement on Occupational Therapy Referral," for guidelines regarding referral for occupational therapy service.
3) Refer to the attached glossary for definitions of terms.
4) The standards are not PSRO screening criteria. AOTA model screening criteria are available for $2.00 from AOTA, Practice Division.

(January 1976 Edition)

b. performance component skills:
    1) motor skills
    2) sensory-integrative skills

4. If any of the above evaluation results indicate possible deficits in:

    a. psychological skills
    b. social skills, and/or
    c. cognitive skills

    the therapist should evaluate these areas and document any functional deficits; or should refer the client to the appropriate service/individual for evaluation.

5. If any of the above evaluation results indicate the client's need for referral to community services or programs, the therapist should determine the availability of such community resources; or should refer the evaluation to the appropriate service/individual.

6. The therapist should obtain information about the client's medical history, education, work history, avocational interests, family, and cultural background. This information may be obtained through client interview, record review, and/or discussion with informed sources.

C. Program Plan Standards

1. When any of the following problems are identified, an occupational therapy program plan shall be developed:

    a. decreased ability for occupational performance (activities of daily living
    b. muscle weakness and/or limited endurance
    c. limited passive range of motion
    d. lack of active motion
    e. abnormal muscle tone
    f. abnormal patterns of movement (synergies)
    g. lack of dexterity and/or coordination
    h. impaired sensation: (tactile, pain, temperature, stereognosis, proprioception)
    i. impaired cognitive functioning (confusion, disorientation, and/or judgment)
    j. impaired head or trunk control
    k. neglect of involved side of the body
    l. depression and/or low self-esteem
    m. pain
    n. inability to communicate basic needs
    o. edema of the hands
    p. visual field deficit
    q. apraxia

2. The therapist shall prepare the program plan based on an analysis of:

   a. the occupational therapy evaluation data
   b. the client's expected prognosis

3. The therapist shall document the program plan within six working days after the acknowledgement of the referral receipt.

4. The documented program plan should consist of a statement of:

   a. achievable program goals
   b. methods to achieve the goals

5. The program plan goals and methods should be consistent with:

   a. the evaluative results and expected prognosis
   b. the goals of the client and/or family
   c. the program plans of other health care practitioners

6. The following chart outlines the goals and acceptable methods for each of the problem areas:

Problem:	Shall include goals of:	Acceptable methods include, but are not limited to:
a. Decreased ability for activities of daily living	. increasing ability for performance of activities of daily living	. treating specific performance components that interfere with function . using repetitive practice of activities of daily living . teaching one-handed methods for performance of activities of daily living . providing and training in the use of assistive devices . developing pre-vocational or avocational interests . giving recommendations to eliminate and/or adapt architechural or environmental barriers to enhance performance in the discharge setting.
b. Muscle weakness and/or limited endurance where there is isolated muscle control	. strengthening	. using graded activity program . using assistive to active to resistive exercise program . using activities of daily living training program
c. Limited passive joint range of motion	. preventing loss of and/or increasing passive range of motion	. teaching self-range of motion . using exercise devices, i.e. pulleys and skateboard . using positioning devices, i.e. splints, slings, pillow, arm rests, lapboards . using graded activity programs

Problem:	Shall include goals of:	Acceptable methods include, but are not limited to:
c. (continued)		. performing passive range of motion or teaching significant others to do so
d. Lack of active motion in the involved extremity	. preventing loss of passive range of motion. For patients seen in an O.T. program within six month of onset, the goal should also include encouraging active motion through the use of any methods which facilitate motion	. any method which facilitates motion
e. Abnormal muscle tone	. preventing loss of passive range of motion	. methods which either facilitate or inhibit tone . passive range of motion . referral to physician for medical management
f. Abnormal patterns of movement of the involved extremity (synergies)	. increasing motor control of the involved extremity	. methods to work through abnormal and facilitate normal patterns of movement. Continued use of methods to increase motor control shall be based on measurable change in the function.
g. Lack of dexterity and/or coordination	. increasing dexterity and/or coordination of the upper extremities	. repetitive use of graded activities or exercises requiring coordination.
h. Impaired sensation	. compensation for sensory impairment	. (not specified at this time)
i. Confusion, disorientation, and/or poor judgment	. decreasing confusion, and/or improving orientation and judgement	. reality orientation program . structuring patient's daily activities or environment

Problem:	Shall include goals of:	Acceptable methods include, but are not limited to:
i. (continued)		. instructing significant others on approaches for patient management . referral for medical management . use of sensory-integrative techniques to increase orientation to the environment
j. Impaired head or trunk control	. improving head and trunk control	. use of strengthening activities when weakness is identified as the cause . use of exercises/activities to enhance postural and equilibrium reactions and to increase awareness of body in space . intermittent use of equipment to challenge control . provision of support equipment as needed . teaching the patient and/or significant others safety precautions
k. Neglect of the involved side	. increasing awareness of the involved side of the body and preventing injury	. sensory stimulation; cognitive input . bilateral activities, especially those requiring crossing into neglected spaces . positioning of body parts where they can be more easily seen and less easily ignored . instructing significant others in the nature of the problem and safety precautions

Problem:	Shall include goals of:	Acceptable methods include, but are not limited to:
l. Depression and/or low esteem	. improving self esteem and alleviating depression	. encouraging and providing opportunity for the expression of feelings . involving the patient in success experiences . helping patient recognize his/her capabilities . referral for medical or psychological management
m. Pain	. decreasing pain If any of the following are causes:	. notifying the physician
	increased muscle tone -----→	using techniques to decrease tone
	unsupported joint -----→	providing support
	joint tightness -----→	range of motion
	edema -----→	using positioning, active exercise and/or providing support
n. Ability to communicate basic needs	. increasing ability to communicate	. exploring alternate methods of communication (exploration may mean referral to or collaboration with speech pathologist)
o. Edema of the hand	. decreasing edema	. elevating of the hand . applying pressure wrap . referring for medical management

Problem:	Shall include goals of:	Acceptable methods include, but are not limited to:
p. Visual field deficit	• compensation for visual field deficit	• teaching patient to scan • increasing cognitive awareness of the problem • using activities that require working in the impaired visual field • instructing significant others on management of the problem
q. Apraxia	• improving function	• using activity programs graded by cognitive requirements • using repetitive practice of similar motor acts using different objects • using graded, repetitive, manual guidance for handling and use of familiar objects • increasing the complexity of functional performance as simpler tasks are mastered • using sensory-integrative techniques

D. Program Implementation Standards

1. The therapist shall implement the occupational therapy program according to the program plan.

2. The therapist shall document at least every five working days, the occupational therapy services provided, the frequency of the services, and the client's progress toward goals.

3. The therapist shall periodically re-evaluate and document the changes in the client's occupational performance and/or performance component skills.
    a. if the client's program exceeds a 3-month period, the client should be re-evaluated at least every two months.
    b. if the client's program is less than three months, the client should be re-evaluated at least once per month.

4. The therapist shall formulate, document and implement program changes consistent with the changes in the client's occupational performance and performance-component-skills.

E. Discharge Standards

1. The therapist shall prepare and document the occupational therapy discharge plan.

2. The discharge plan shall be consistent with the client's goals, functional abilities and deficits, community resources, and expected prognosis.

3. The discharge plan should be consistent with the discharge plans of the other health care practitioners.

4. In the preparation of the discharge plan, the therapist should allow enough time for coordination, acceptance, and effective implementation of the discharge plan.

5. The therapist shall document within two days following discharge, the client's functional abilities and deficits in occupational performance and performance component skills at the time of discharge.

6. The therapist shall recommend discontinuation of occupational therapy services when the client has achieved the program goals and/or has achieved maximum benefit from the services.

January 1976

Standards of Practice for Occupational Therapy Services
for the Client with Arthritis [1]

Introduction to Process and Outcome Standards

There are two different types of standards which can be used to determine a therapist's quality level of performance: process standards and outcome standards.

Process standards state what the therapist does; the procedures that must or should be performed, e.g. "Therapist shall evaluate range of motion and document the evaluative results in the medical chart."

Outcome standards state the expected end-results of the treatment; what the client is expected to achieve or be able to do as a result of the treatment, e.g. "At the conclusion of the treatment program, the patient shall not have lost active or passive range of motion." One of the advantages of using outcome standards for assessing the quality of treatment is that outcome standards allow the clinician more freedom to determine the treatment methodology.

In developing the standards for the treatment of clients with arthritic conditions, the task force developed general standards for all the major rheumatic diseases of the occupational therapy client population. The task force developed additional outcome standards for the post-surgical phase, for systemic manifestations and for specific joint disease.

Process Standards

A. Referral Standards[2]

1. If a referral is received, the therapist shall document:
    - a. the date of receipt and referral source
    - b. the services requested
    - c. the above (a&b) within one working day of the receipt of the referral

---

1) These standards have been developed by occupational therapists working under the auspices of the AOTA Continuing Certification Program and the AOTA-HEW Continuing Competency Contract No. NO1-AH-44116. These standards are available for use in a self-assessment or peer review program; however, they are not official AOTA standards until approved by the AOTA Delegate Assembly. Any questions regarding their use should be directed to the AOTA Director of Certification.

2) Refer to the attached AOTA "Statement on Occupational Therapy Referral," for guidelines regarding referral for occupational therapy service.

(January 1976 Edition)

B. Evaluation Standards[3]

1. The therapist shall orient the client, family and/or significant others to the purposes and procedures of the occupational therapy evaluation.

2. The evaluation shall be completed and the results documented within at least five working days after acknowledgement of referral receipt.

3. The evaluation shall include (but need not be limited to) an initial assessment of the client's goals, and functional abilities and deficits in:

   a. occupational performance (activities of daily living):
      1. self-care skills
      2. work skills
      3. play/leisure skills

   b. performance components:
      1. motor skills:
         a) active and passive range of motion of affected joints;
         b) muscle strength (within pain-free ROM)
         c) endurance; level of activity tolerance

4. The evaluation shall also include (but need not be limited to) an initial assessment of:

   a. the client's perception of the disease process and its effect on daily living activities

   b. the client's goals or values

   c. the client's initial expectations of treatment outcomes

5. The evaluation shall also include (but need not be limited to) an initial assessment of:

   a. the client's ability to utilize the physical facilities and equipment within the living and/or working environment

6. If any of the above evaluation results indicate the client's need for referral to community services or programs, the therapist should determine the availability of such community resources; or should refer the evaluation to the appropriate service/individual.

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3) Refer to the attached glossary for definitions of terms.

4) The standards are not PSRO screening criteria. AOTA model screening criteria are available for $2.00 from AOTA, Practice Division.

7. If any of the above (items 3, 4, 5) evaluation results indicate possible deficits in psychological or social skills, the therapist should evaluate and document any functional deficit in psychological or social skills; or should refer the client to the appropriate service/individual for evaluation.

8. The therapist should obtain information about the client's medical history, education, work history, avocational interests, family, and cultural background. This information may be obtained through client interview, record review, and/or discussion with informed sources.

C. Program Plan Standards

1. The therapist shall prepare and document a program plan based on an analysis of:

   a. the occupational therapy evaluation data
   b. the client's expected prognosis

2. The therapist shall document the program plan within six working days after the acknowledgement of the referral receipt.

3. The documented program plan should consist of a statement of:

   a. achievable program goals
   b. methods to achieve the goals

4. The program plan goals and methods should be consistent with:

   a. the evaluative results and expected prognosis
   b. the goals of the client and/or family
   c. the program plans of other health care practitioners

5. When the evaluation results indicate a problem in any of the following areas and if there are no medical restrictions, the program plan shall include the following methods:

   a. occupational performance (activities of daily living): instruct the client in adapted methods of performing activities of daily living. The therapist may:
      1. teach adaptation of methods
      2. provide adapted or assistive equipment
      3. adapt equipment and/or environment
      4. discuss alternative methods of pursuing former vocational and avocational activities

5. discuss and develop new avocational interests and skills which are satisfying to client's needs and are not harmful to affected joints.
6. discuss the effect of the disease on the client's ability to perform activities of daily living

b. motor skills:

1. provide instruction in kinetic activities designed to increase and/or maintain passive and active range of motion. The therapist shall explain the importance of accurately following the instructions and shall evaluate the client's abilities to accurately follow through with the instructions.
2. design, fabricate and/or fit orthotic devices as approved by physician; or shall recommend the design of orthotic devices to be constructed by another specialist; instruct the client in the rationale for the orthotic device; the use and care of the device; precautions to be observed
3. instruct the client in general principles of joint protection, this shall include instruction in:
    1. proper body mechanics
    2. avoidance of static and/or deforming postures
    3. work simplification techniques
    4. need for proper balance of rest and activity

c. community resources:

discuss with the client those community resources which are available to meet his or her needs in the areas of: employment, recreation, socialization, transportation, additional therapy services and list sources for adaptive and/or exercise equipment.

d. psychological skills:

provide psychological support; provide opportunities for client to express feelings, and to develop self-esteem and self concept.

e. home program:

develop, discuss and document a home program:
1. explain the rationale for the program
2. instruct client in the program
3. explain precautions to be followed
4. ask client to demonstrate the program; correct client as needed
5. periodically discuss home program with client; adjust the program as needed.

D. Program Implementation Standards

1. The therapist shall implement the occupational therapy program according to the program plan.

2. The therapist shall document at least every five working days, the occupational therapy services provided, the frequency of the services, and the client's progress toward goals.

3. The therapist shall document the following symptoms (or changes in symptoms) if noted:

    a. joint swelling, tenderness, inflammation
    b. pain
    c. stiffness
    d. muscle tenderness and atrophy
    e. skin changes; nodules
    f. increased joint deformity
    g. decreased sensation

4. The therapist shall periodically re-evaluate and document the changes in the client's occupational performance and/or performance component skills.

    a. if the client's program exceeds a three-month period, the client should be re-evaluated at least every two months.
    b. if the client's program is less than three months, the client should be re-evaluated at least once per month.

5. The therapist shall formulate, document and implement program changes consistent with the changes in the client's occupational performance and performance component skills.

E. Discharge Standards

1. The therapist shall prepare and document the occupational therapy discharge plan.

2. The discharge plan shall be consistent with the client's goals, functional abilities and deficits, community resources, and expected prognosis.

3. The discharge plan should be consistent with the discharge plans of the other health care practitioners.

4. In preparation for the discharge plan the therapist should allow enough time for coordination, acceptance, and effective implementation of the discharge plan.

5. The therapist shall document within two days following discharge, the client's functional abilities and deficits in occupational performance and performance-component-skills at the time of discharge.

6. The therapist shall recommend discontinuation of occupational therapy services when the client has achieved the program goals and/or has achieved maximum benefit from the services.

Outcome Standards

A. General Standards:

These general standards are applicable to clients with any type of arthritis; when necessary, additional outcome standards are stated for a specific form of arthritis.

These outcome standards state what the client is expected to achieve or be able to do as a result of the occupational therapy program.

In order to assess an occupational therapy program with these outcome standards, the therapist must document information which will clearly indicate the client's achievement or lack of achievement of each of the following goals:

1. The client can state, within the limits of his or her capabilities, a general explanation of how the disease process affects his or her ability to perform activities of daily living.
2. The client can perform, within the limitation of the disability, those activities of daily living which are normally performed by someone of his or her age and role.
3. The client can verbalize an understanding of and practices a balance of rest and activity, work simplification techniques for energy conservation in his or her daily routine or activities.
4. The client can explain principles of joint protection/preservation and incorporates them into his or her daily routine.
5. The client uses proper body positioning and body mechanics during rest and/or activity.

6. The client performs kinetic activites as instructed; observes necessary precautions.
7. The client can explain the rationale for the use of appropriate kinetic activities (activities to improve or maintain range of motion, strength, posture, breathing capacity and/or endurance).
8. The client has same or increased active and passive range of motion and strength on last day treated as on first day measured.
9. The orthotic device met the needs for which it was provided; e.g. decrease of pain, increase of function; prevention of deformity.
10. The client can state a general explanation of the rationale for the use of orthotic devices; and observes precautions.
11. The client can demonstrate the application, removal and care of orthotic devices.
12. The client correctly uses the adapted or assistive device.
13. Modification of the structural arrangement and/or equipment in the client's environment has increased the client's ability to function in the environment.
14. The client correctly follows the home program.
15. The client's family can state a general explanation of the disease process, the rationale for the occupational therapy program, the home program, and the required activity restrictions.
16. The client and/or significant others can describe arrangements made to assist the client in activities he or she is unable to perform at discharge.

B. Outcome Standards for the Post-Surgical Phase:

Standards are the same as those listed under the general standards with the following additions:

1. Client can state within the limit of his/her capabilities, a general explanation of the relationship of the occupational therapy program to the surgical procedure.
2. Post-operatively, client can explain and demonstrate the post-operative exercises and/or splinting program.
3. Client can explain the rationale for and observe post-operative positioning, exercise and activity precautions, including correct body alignment while lying, sitting, ambulating, or transferring.
4. During surgical post-operative recovery period, the client functions at maximal level of independence in activities of daily living, and receives assistance for those activities and/or tasks he or she is unable to perform in the treatment setting.
5. Client's family or significant others can state a general explanation of the rationale for occupational therapy program and activity restrictions specific to the surgical procedure.

C. Outcome Standards for Clients with Systemic Manifestations of Rheumatoid Arthritis:

Standards are the same as those listed under the general standards with the following additions:

1. Client can explain and observes in his or her daily routine, the safety and/or activity precautions relative to systemic involvement (gastrointestinal, renal, cardiac, pulmonary, or visual complications) as instructed or informed.

D. Outcome Standards for Clients with Polymyositis and Dermatomyositis

1. Introduction

   Treatment for polymyositis is controversial and dependent upon the treatment philosophy of the supervising physician. The therapist should be in direct contact with the physician in order to adjust the client's therapeutic regimen and activity level to muscle pathology as determined by muscle enzyme levels.

2. Standards for treatment of manifestations of joint involvement and/or arthralgia are the same as the general standards.

3. Standards for clients with muscle involvement:

   a. Client uses prescribed ambulation aids consistently and as instructed, observing safety precautions against falling during ambulation and transfer.

   b. When there is dysphagia secondary to esophageal involvement client observes, or can instruct others in necessary safety precautions relative to eating.

   c. Client observes appropriate positioning while lying or sitting, including use of neck supports while sitting.

   d. Client performs daily strengthening exercises as prescribed.

   e. Client performs range-of-motion exercises daily, as instructed.

E. Outcome Standards for Clients with Articular and/or Systemic Manifestations of Juvenile Rheumatoid Arthritis

Standards are the same as the general standards , with the following additions:

1. The child and/or responsible others can demonstrate an understanding of, and observes in his or her daily routine, the safety and/or activity precautions relative to systemic involvement (gastro-intestinal, renal, cardiac, pulmonary or visual complications) as instructed or informed.
2. For client unable to manage a home program, parents or significant responsible others can demonstrate treatment techniques and supervise treatment followthrough.

3. Client's responsible others can describe appropriate activities for the child's developmental level to prevent or compensate for developmental lags attributable to illness.

F. Outcome Standards for Clients with Ankylosing Spondylitis

Standards are the same as the general standards for joint disease, with the following additions:

1. Client can explain the need for balanced rest and activity, and takes safety precautions against falling, bending or stooping.
2. Client can describe and observes in his/her daily routine the safety and/or activity precautions relative to systemic involvement (gastro-intestinal, renal, cardiac, pulmonary, or visual complications) as instructed or informed.
3. Client can state rationale for exercise program and maintains optimal posture as instructed.
4. Client performs postural and breathing exercises daily as instructed.

G. Outcome Standards for Clients with Systemic Lupus Erythematosis

Standards for articular involvement are the same as the general standards, with the following additions:

1. Client can describe and observe in his/her daily routine, the safety and/or activity precautions relative to systemic involvement (gastro-intestinal, renal, cardiac, pulmonary or visual complications) as instructed or informed.
2. Clients who are sensitive to ultra-violet or sunlight can state an awareness of exacerbating effects, and of protective techniques.

H. Outcome Standards for Clients with Progressive Systemic Sclerosis

Standards for articular involvement are the same as the general standards, with the following additions:

1. Client can describe and observes in his/her daily routine, the safety and/or activity precautions relative to systemic involvement (gastro-intestinal, renal, cardiac, pulmonary or visual complications) as instructed or informed.
2. Client performs daily range-of-motion exercises (including deep breathing to maintain chest expansion), and facial exercises to preserve oral opening.
3. Client's family and significant others can explain the rationale for the need for specific attention to dental care.
4. When necessary, client observes precautions for Raynaud's phenomenon and skin ulcerations.

THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.
6000 Executive Boulevard, Rockville, Maryland 20852

STATEMENT ON
OCCUPATIONAL THERAPY REFERRAL

INTRODUCTION

The American Occupational Therapy Association presents a statement to clarify publicly the position of the profession relative to referral for occupational therapy service and responsibility to the medical management plan of the patients treated.

> Considered within this statement are the qualified occupational therapist and the qualified occupational therapy assistant; each having satisfactorily completed the formal academic and clinical preparation requisite to his level, professional or assistant, and successfully entered into and held current the registration or certification which signifies his level and identifies him as a registered occupational therapist (O.T.R.) or a certified occupational therapy assistant (C.O.T.A.)

Occupational therapy shares with the physician a dedication to the treatment of patients and protection of their welfare. It maintains a close relationship to medicine, which it continually strengthens as ever increasing professional skills enable it to provide a more discrete, competent service.

Occupational therapy also shares with the physician a concern for individual and community health and therefore extends its contribution beyond restorative measures and acute treatment concerns to the maintenance of health and prevention of disease and disability.

I. The registered occupational therapist (O.T.R.) and the certified occupational therapy assistant (C.O.T.A.)respond to a request for service whatsoever its source; the O.T.R. enters a case at his own professional descretion and on his own cognizance, the C.O.T.A. enters as authorized by his supervising O.T.R., and each:

- recognizes that the physician, duly licensed by the appropriate body to practice medicine and surgery, is the person who holds full responsibility for the medical management of a patient; and
- practices within the limits of competency and the supervisory pattern commensurate with his level of qualification, professional or assistant; and
- implements occupational therapy's concepts and provides judgment and skill in the evaluation of a patient and formulation of his comprehensive, continuing medical management and care plan;
  - refers a case which, in his judgment, appears to be a medical one lacking physician management, to a qualified physician for medical management, and
  - treats, within the patient management plan, collaboratively with all others who care for the patient, and apprises the physician and appropriate supportive personnel of his findings and actions, all of which he documents in the legal medical record; and
- implements occupational therapy's concepts and provides judgment and skill in the evaluation of a client, and the formulation of a health program directed

toward the maintenance of his health and freedom from disease, disability or dependence;

- refers a client who, in his judgment, appears to be a medical case lacking medical management to a qualified physician, or a client in need of social, vocational or other specialized management to one professionally qualified to provide it; and

- guides the client in the utilization of the concepts of occupational therapy where applicable to the improvement of his general welfare; apprises collaborations personnel of occupational therapy's findings and actions, and documents same in the client's record.

II. The registered occupational therapist (O.T.R.) and the certified occupational therapy assistant (C.O.T.A.), each on his own cognizance, respond to requests of qualified agencies, facilities, programs and personnel for collaboration in activities directed to the general health of society, and within the expertise of his level of qualification each:

- contributes to the evaluation of health factors, the development, utilization and interpretation of health knowledge and its dissemination especially as it pertains to the use or absence of activity and its influence upon individual and societal health; and

- initiates entry into such activities where otherwise society would be deprived of the benefit of the concepts and philosophy of occupational therapy.

III. When the registered occupational therapist (O.T.R.) or certified occupational therapy assistant (C.O.T.A.) is employed or volunteers as an activity program director, worker or consultant he contributes to a diversional, social or recreational program, in which individuals who do or do not have health problems, may, with their physician's knowledge, elect to participate for the improvement of their general welfare; and, in accordance with said position classification he:

- serves as activity program worker or director (appropriately the C.O.T.A.) without a physician's referral, but with access to the medical record for knowledge of the precautions he must observe and participant performance he should report; or

- serves as a consultant (appropriately the O.T.R.) to the activity program and to its supporting facility without physician referral, to provide a rehabilitation approach, take advantage of the therapeutic value of activity, enrich participant involvement and identify those individuals among the participants who are in need of specific referral for occupational therapy.

Adopted June 1969

GLOSSARY OF TERMS USED IN THE OCCUPATIONAL THERAPY STANDARDS OF PRACTICE[1]

1. Abnormal patterns of motion (synergies): certain primitive patterns of motion which typically appear to varying degrees in the hemiplegic individual when isolated movement is attempted. These patterns may be seen in the extremities in stereotyped flexion and extension patterns as distinguished from normal, coordinated, voluntary motion which is also synergistic in nature.

2. Activities of daily living: (see definition of occupational performance.)

3. Activity restriction: The exclusion of certain activities, or restrictions in method or duration of performance.

4. Assistive/adaptive equipment: a special device which assists in the performance of self care, work or play/leisure activities or physical exercises.

5. Cognitive skills: the level, quality, and/or degree of comprehension, communication, concentration, problem solving, time management, conceptualization, integration of learning, judgment, and time-place-person orientation.

6. Community services, programs or resources: vocational, social, religious, recreational, health, education and transportation services or programs that may be available in the community.

7. Coordination: the ability to perform motions in a smooth concerted way.

8. Dexterity: skill and ease in performing physical activities.

9. Document: the written recording of information in the client's overall record/chart and/or in the occupational therapy record/chart.

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[1] This glossary has been prepared by occupational therapists working under the auspices of the AOTA Continuing Competency Program and the AOTA-HEW Continuing Competency Contract NO1-AH-44116. This glossary is not an AOTA official glossary. Any questions regarding the use of the glossary should be directed to the AOTA Director of Certification. January 1976

10. Evaluate/evaluation: the process of collecting and interpreting data obtained through observation, interview, record review, or testing.

11. Environmental adaptations: structural or positional changes designed to facilitate independent living and/or increase safety in the home, work or treatment setting; i.e., the installation of ramps, bars; change in furniture heights; adjustment of traffic patterns.

12. Facilitation techniques: specific treatment which attempts to encourage motion in a non-functioning muscle or muscle group.

13. Inhibition techniques: specific treatment which attempts to decrease muscle tone or excess motion that interferes with function.

14. Joint protection/preservation: the principles or techniques of minimizing stress on joints. Includes the use of proper body mechanics; avoidance of excessive weight-bearing, static, or deforming postures.

15. Kinetic activities: those activities requiring motion. Can include activities of daily living and isometric, assistive, resistive exercises.

16. Life space: an individual's cultural background, value orientation, and environment.

17. Life style: the degree, range and balance of self care, work, and play/leisure activities.

18. May: indicates an acceptable method that is recognized, but not necessarily preferred.

19. Motor skills: the level, quality and/or degree of range of motion, gross muscle strength, muscle tone, endurance, fine motor skills, and functional use.

20. Occupational performance: the performance of self-care, work and play/leisure activities, the activities of daily living. The performance of these activities requires self-care, work, and play/leisure skills. The concept of occupational performance is further described in the delineation of roles and functions in Appendix V.

21. Performance components: the learned and developmental patterns of behavior which are the prerequisite foundations of self care, work, and play/leisure skills.

    The performance components include:

    a. Motor skills
    b. Sensory-integrative skills
    c. Cognitive skills
    d. Psychological/intrapersonal skills
    e. Social/interpersonal skills

22. Play-leisure skills: those skills necessary to perform and engage in activities such as games, sports, and hobbies.

23. Positioning: the placing of body parts in proper alignment.

24. Psychological/intrapersonal skills: the level, quality and/or degree of self-identity, self-concept, and coping skills.

    a. self-identity and self concept: the ability to perceive self needs and expectations from those of others; identify areas of self-competency and limitations; accept responsibility for self; perceive sexuality of self; have self respect; have appropriate body image; view self as being able to influence events.

    b. coping skills: includes the ability to subliminate drives, find sources of need gratification, tolerate frustration and anxiety, experience gratification, and control impulses.

25. Reality orientation: the treatment approach aimed at reinforcement of reality, i.e. the use of simple, structured activities for orientation to time, place, and person.

26. Self care skills: skills such as dressing, feeding, hygiene/grooming, mobility, and object manipulation.

    a. mobility: skills such as getting in/out of bed, chair, wheelchair, vehicles and utilizing transportation.

    b. object manipulation: skills such as the handling of common objects such as telephone, keys, money, light switches, doorknobs.

27. Sensation: perception of stimuli, includes touch, pain, temperature, stereognosis, proprioception, taste, smell, kinesthesia, vision, hearing.

28. Sensory-integrative skills: the level, quality, and/or degree of body schema, praxis, posture and body integration, visual-spatial relationships, sensory-motor integration, reflex and sensory status.

29. Shall or must: indicates a mandatory statement; the only acceptable method.

30. Should: indicates the commonly accepted method, yet allows for the use of effective alternatives.

31. Significant others: persons who have an important relationship to the client. This could include the client's family, friends, employer, teacher, or other health care providers.

32. Social/interpersonal skills: the level, quality, and/or degree of dyadic and groups interaction skills.

    a. dyadic interaction skills: abilities in relationships to peers, subordinates, and authority figures; demonstrating trust, respect, and warmth; perceiving and responding to needs and feelings of others; engaging in and sustaining interdependent relationships; communicating feelings.

    b. group interaction skills: abilities in performing tasks in the presence of others; sharing tasks with others; cooperating and competing with others; fulfilling a variety of group membership roles; exercising leadership skills; perceiving and responding to needs of group members.

33. Splinting: the provision of dynamic and/or static splints for the purpose of: relieving pain, maintaining joint alignment, protecting joint integrity, improving function, and/or decreasing deformity.

34. Structuring environment: the organization of the client's time, activities, and/or physical environment in order to enhance performance. (see environmental adaptations)

35. Work simplification: the streamlining of the performance of an activity in order to minimize energy out-put.

36. Work skills: skills such as work habits, workmanship, actual skills related to specific job tasks. The skills may refer to the work of the student, home manager, or paid employee. Home manager skills include such skills as cooking, budgeting, shopping, clothing maintenance, house cleaning and maintenance.

APPENDIX X

Data Abstract Forms for Chart Audit/Record Review

in the five speciality areas:

- Mental Health
- Developmental Disabilities
- Physical Disabilities
  - Stroke
  - Arthritis

Prepared under the auspices of the AOTA Continuing Competency Project
Contract No. NO1-AH-44116.

January 1976

American Occupational Therapy Association, Inc.

DATA ABSTRACT FORM FOR RECORD REVIEW	Standard was: 1	2	3	4	COMMENTS:
Standards of Practice for Occupational Therapy Services in a Mental Health Program [1]	met	not applicable	not met: with justification	not met: no justification	
Client's name: ________________; age: ________ record number: ________; date of review: ________ diagnosis: ________________; therapist: ________ ________________; reviewer: ________					
A. Referral Standards [2, 3]					
1. The therapist:					
a. documented the date of receipt and referral source					
b. documented the occupational therapy services requested					
B. Evaluation Standards					
1. The therapist evaluated and documented the client's goals, functional abilities and deficits in occupational performance (activities of daily living):					
a. self-care skills					
b. work skills					
c. play/leisure skills					

---

1) The standards have been developed by occupational therapists working under the auspices of the AOTA Continuing Certification Program and the AOTA-HEW Continuing Competency Contract No. 1-AH-44116. The standards are available for use in a self-assessment or peer review program; however, they are not official AOTA standards until approved by the AOTA Delegate Assembly. Any questions regarding their use should be directed to the AOTA Director of Certification.

2) The attached AOTA "Statement on Occupational Therapy Referral," is a guideline for referral for occupational therapy service.

3) The attached narrative statement on the standards and the glossary of terms should be used as a explanatory reference throughout the record review.

4) The standards are not PSRO screening criteria. AOTA model screening criteria are available for $2.00 from AOTA, Practice Division.

(January 1976 Edition)

DATA ABSTRACT FORM FOR RECORD REVIEW
Page 2 Mental Health

COMMENTS:

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS:
2. The therapist evaluated and documented the client's goals, functional abilities and deficits in the following performance component areas:					
a. psychological/intrapersonal skills					
b. social/interpersonal skills					
c. cognitive skills					
3. When the results of the occupational performance evaluation indicated possible deficits in the client's motor and/or sensory-integrative skills, the therapist evaluated these areas and documented functional deficits; or referred the client to another practitioner for evaluation.					
4. When any of the above evaluation results indicated the client's need for referral to community services or programs, the therapist determined the availability of such community resources; or referred the evaluation to another practitioner.					
C. Program Plan Standards					
1. The documented program plan consisted of a statement of achievable program goals and the methods to achieve the goals.					
2. The program plan goals and methods were consistent with the evaluation data on the client's goals, functional abilities and deficits, community resources and prognosis.					
3. The program plan goals and methods were compatible with the program plans of the other health care practitioners.					

DATA ABSTRACT FORM FOR RECORD REVIEW

page 3 Mental Health

	Standard was:				COMMENTS:
	1	2	3	4	
COMMENTS:	met	not applicable	not met: with justification	not met: no justification	
D. Program Implementation Standards					
1. The therapist implemented the occupational therapy program according to the program plan. (refer back to documented program plan goals and methods)					
2. The therapist periodically documented the occupational therapy services provided and the frequency of the services.					
3. The therapist periodically re-evaluated and documented the changes in the client's occupational performance and performance component skills.					
4. The therapist formulated, documented and implemented program changes consistent with changes in the client's occupational performance and performance component skills.					
E. Discharge Standards					
1. The therapist prepared and documented the occupational therapy discharge plan.					
2. The discharge plan was consistent with the client's goals, functional abilities and deficits, community resources, and prognosis.					
3. The discharge plan was consistent with the discharge plans of the other health care practitioners.					
4. Sufficient time was allowed for coordination, acceptance and effective implementation of the discharge plan.					

DATA ABSTRACT FORM FOR RECORD REVIEW

page 4 Mental Health

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS:
COMMENTS:					
5. The therapist documented the client's functional abilities and deficits in occupational performance and performance component skills at time of discharge.					
6. The therapist terminated occupational therapy services when the client had achieved the goals; or when the client had achieved maximum benefit from occupational therapy.					
F. Follow-up Standards For clients with chronic condition:					
1. The therapist re-evaluated the client at an appropriate time interval following discharge.					
2. The re-evaluation results were documented.					
3. If the client needed further service, the therapist referred the client to the services needed.					

January 1976

American Occupational Therapy Association, Inc.

DATA ABSTRACT FORM FOR RECORD REVIEW	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS:
Standards of Practice for Occupational Therapy Services for the Developmentally Disabled Client [1]					
Client's name:________________; age:__________ record number:__________; date of review:__________ diagnosis:________________; therapist:__________ ____________________; reviewer:__________					
A. Referral Standards 2, 3					
1. The therapist:					
a. documented the date of receipt and referral source					
b. documented the occupational therapy services requested					
B. Evaluation Standards					
1. The occupational therapy evaluation included an assessment of the developmental level, as well as the functional abilities and deficits in the following areas:					
a. occupational performance (activities of daily living):					
1) self-care skills					
2) home-work-school skills					
3) play/leisure skills					

---

1) The standards have been developed by occupational therapists working under the auspices of the AOTA Continuing Certification Program and the AOTA-HEW Continuing Competency Contract No. 1-AH-44116. The standards are available for use in a self-assessment or peer review program; however, they are not official AOTA standards until approved by the AOTA Delegate Assembly. Any questions regarding their use should be directed to the AOTA Director of Certification.
2) The attached AOTA "Statement on Occupational Therapy Referral," is a guideline for referral for occupational therapy service.
3) The attached narrative statement on the standards and the glossary of terms should be used as a explanatory reference throughout the record review.
4) The standards are not PSRO screening criteria. AOTA model screening criteria are available for $2.00 from AOTA, Practice Division.

(January 1976 Edition)

DATA ABSTRACT FORM FOR RECORD REVIEW

page 2 Developmentally Disabled Cient

COMMENTS:

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS:
b. motor skills					
c. sensory-integrative skills					
2. When the results of the above evaluation (l.a.b. or c.) indicated possible deficits in psychological/social and/or cognitive skills, the therapist evaluated these areas and documented functional deficits; or referred the client to the appropriate service/individual.					
3. When any of the above evaluation (l.a.b.c. and/or 2) results indicated the client's need for referral to community services or programs, the therapist determined the availability of such community resources; or referred the evaluation to the appropriate service/individual.					
4. The evaluation methods were appropriate to the chronological age and functional level of the client.					
5. When standardized evaluative tests were used, the tests had normative data for the age range of the client. If normative data for the age range of the client were not available, the standardized test results were expressed in relation to the normative data that were available.					
6. The therapist documented the evaluation results in the client's record.					
C. Program Plan Standards					
1. The documented program plan consisted of a statement of achievable program goals and the methods to achieve the goals.					

DATA ABSTRACT FORM FOR RECORD REVIEW

page 3 Developmentally Disabled Client

COMMENTS:

Standard was:	1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS:
COMMENTS:					
2. The program plan goals and methods were consistent with:					
a. established principles of normal growth and development					
b. the evaluative results and expected prognosis					
c. the goals of the client's family and significant others					
d. the program plans of the other health care practitioners					
3. When the occupational therapy program goal was to prevent or diminish dysfunction in occupational performance (activities of daily living) or to enhance occupational performance, the program plan included the (but need not be limited to) use of one or more of the following types of activities:					
a. self-care activities; may also include instruction in the use of adapted methods and/or equipment					
b. home-work-school activities; may also include instruction in the use of adapted methods and/or equipment					
c. play/leisure activities; may also include instruction of family in play activities appropriate for child's developmental level; instruction in the use of adapted methods and/or equipment					

DATA ABSTRACT FORM FOR RECORD REVIEW

page 4 Developmentally Disabled Client

COMMENTS:	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS:
4. When the goal was to prevent or diminish neuromuscular dysfunction or enhance neuromuscular development, the program plan included (but need not be limited to) the use of one or more of the following types of activities:					
a. activities which maintain or increase range of motion and/or muscle strength					
b. activities which facilitate integration of developmentally appropriate reflex behavior					
c. activities which provide sensory stimulation					
d. activities which promote the development of desired movement patterns and motor control					
e. activities which maintain or increase coordination					
f. instruction in use of proper positioning techniques					
g. provision of and instruction in the use of adaptive equipment and/or orthotic devices					
5. When the goal was to prevent or diminish sensory-integrative dysfunction or to enhance sensory-integrative development, the program plan included (but need not be limited to) the appropriate use of one or more of the following techniques:					
a. sensory stimulation techniques for visual, auditory, gustatory, olfactory, tactile, proprioceptive, kinesthetic, and/or vestibular stimulation					
b. facilitation techniques					
c. inhibition techniques					

DATA ABSTRACT FORM FOR RECORD REVIEW

page 5 Developmentally Disabled Client

COMMENTS:

COMMENTS:

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification
6. When the goal was to prevent or diminish psychological dysfunction or to enhance psychological development, the program plan included (but need not be limited to) the use of activities which assist the client in learning to:				
a. experience and cope with competition, frustration, success, failure; and/or				
b. express feelings; and/or				
c. develop self esteem; self identity				
7. When the goal was to prevent or diminish social dysfunction or to enhance social development, the program plan included (but need not be limited to) the use of activities which assist the client in learning to:				
a. imitate and develop appropriate social behavior; and/or				
b. listen and communicate; and/or				
c. develop sensitivity to other persons' feelings and behavior				
8. When the goal was to prevent or diminish cognitive dysfunction or to enhance cognitive development, the program plan included (but need not be limited to) the use of activities which assist the client in developing:				
a. concentration/attention span; and/or				
b. memory/recall; and/or				
c. decision making and problem solving skills				
D. Program Implementation Standards				
1. The therapist implemented the program according to the program plan. (refer back to documented program plan and methods)				

DATA ABSTRACT FORM FOR RECORD REVIEW
page 6 Developmentally Disabled Client

	Standard was: 1	2	3	4	COMMENTS:
COMMENTS:	met	not applicable	not met: with justification	not met: no justification	
2. The therapist periodically documented the occupational therapy services provided and the frequency of the services.					
3. The therapist periodically re-evaluated and documented the changes in the client's occupational performance and performance component skills.					
4. The therapist formulated, documented and implemented program changes consistent with changes in the client's occupational performance and performance component skills.					
E. Discharge Standards					
1. The therapist prepared and documented the occupational therapy discharge plan.					
2. The discharge plan was consistent with the client's goals, functional abilities and deficits, community resources, and prognosis.					
3. The discharge plan was consistent with the discharge plans of the other health care practitioners.					
4. Sufficient time was allowed for coordination, acceptance and effective implementation of the discharge plan.					
5. The therapist documented the client's functional abilities and deficits in occupational performance and performance component skills at time of discharge.					
6. The therapist terminated occupational therapy services when the client had achieved the goals; or when the client had achieved maximum benefit from occupational therapy.					

January 1976

American Occupational Therapy Association, Inc.

DATA ABSTRACT FORM FOR RECORD REVIEW	Standard was: 1	2	3	4	COMMENTS:
Standards of Practice for Occupational Therapy Services for Clients with Physical Disabilities [1]	met	not applicable	not met: with justification	not met: no justification	
Client's name: ____________; age: ________ record number: ________; date of review: ________ diagnosis: ____________; therapist: ________ ____________; reviewer: ________					
A. Referral Standards [2, 3]					
1. The therapist documented:					
a. the date of receipt and referral source					
b. the services requested					
c. the above (a&b) within one working day of the referral receipt					
B. Evaluation Standards					
1. The initial evaluation was completed and the results documented within at least five working days after acknowledgement of referral receipt.					

---

1) The standards have been developed by occupational therapists working under the auspices of the AOTA Continuing Certification Program and the AOTA-HEW Continuing Competency Contract No. 1-AH-44116. The standards are available for use in a self-assessment or peer review program; however, they are not official AOTA standards until approved by the AOTA Delegate Assembly. Any questions regarding their use should be directed to the AOTA Director of Certification.
2) The attached AOTA "Statement on Occupational Therapy Referral," is a guideline for referral for occupational therapy service.
3) The attached narrative statement on the standards and the glossary of terms should be used as a explanatory reference throughout the record review.
4) The standards are not PSRO screening criteria. AOTA model screening criteria are available for $2.00 from AOTA, Practice Division.

(January 1976 Edition)

DATA ABSTRACT FORM FOR RECORD REVIEW page 2 Physical Disabilities	Standard was:				COMMENTS:
	1	2	3	4	
COMMENTS:	met	not applicable	not met: with justification	not met: no justification	
2. The initial evaluation included an initial assessment of the client's goals, and functional abilities and deficits in:					
a. self-care skills					
b. work skills					
c. play/leisure skills					
3. The evaluation included an assessment of the client's functional abilities and deficits in:					
a. motor skills					
4. When any of the above (3 and/or 4) evaluation results indicated possible deficits in: a. sensory-integrative skills; and/or b. psychological skills; and/or c. social skills, and/or d. cognitive skills, the therapist evaluated these areas and documented any functional deficits; or referred the client to the appropriate service/individual for evaluation.					
5. When any of the above (3., 4., and/or 5.) evaluation results indicated the client's need for referral to community services or programs, the therapist determined the availability of such community resources; or referred the evaluation to the appropriate service/individual.					

DATA ABSTRACT FORM FOR RECORD REVIEW
page 3 Physical Disabilities

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS:
COMMENTS:					
C. Program Plan Standards					
1. The therapist documented the program plan within six working days after the acknowledgement of the referral receipt.					
2. The documented program plan consisted of a statement of:					
a. achievable program goals					
b. methods to achieve the goals					
3. The program plan goals and methods were consistent with:					
a. the evaluative results and expected prognosis					
b. the goals of the client and/or family					
c. the program plans of other health care practitioners					
D. Program Implementation Standards					
1. The therapist implemented the occupational therapy program according to the program plan. (refer back to documented program plan goals and methods)					
2. The therapist documented, at least every five working days, the occupational therapy services provided, the frequency of the services, and the client's progress toward goals.					

DATA ABSTRACT FORM FOR RECORD REVIEW

page 4 Physical Disabilities

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS:
COMMENTS:					
3. The therapist periodically re-evaluated and documented the changes in the client's occupational performance and/or performance component skills.					
a. if the client's program exceeded a 3-month period, the client was re-evaluated at least every two months.					
b. if the client's program was less than three months, the client was re-evaluated at least once per month.					
4. The therapist formulated, documented, and implemented program changes consistent with the changes in the client's occupational performance and performance/component/skills.					
E. Discharge Standards					
1. The therapist prepared and documented the occupational therapy discharge plan.					
2. The discharge plan was consistent with the client's goals, functional abilities and deficits, community resources, and prognosis.					
3. The discharge plan was consistent with the discharge plans of the other health care practitioners.					
4. In the preparation of the discharge plan, the therapist allowed enough time for coordination, acceptance, and effective implementation of the discharge plan.					

DATA ABSTRACT FORM FOR RECORD REVIEW

page 5 Physical Disabilities

COMMENTS:

COMMENTS:

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification
5. The therapist documented within two working days following discharge, the client's functional abilities and deficits in occupational performance and performance/component/skills at the time of discharge.				
6. The therapist recommended discontinuation of occupational therapy services when the client achieved the program goals and/or achieved maximum benefit from the services.				

January 1976

American Occupational Therapy Association, Inc.

DATA ABSTRACT FORM FOR RECORD REVIEW	Standard was: 1	2	3	4	COMMENTS:
Standards of Practice for Occupational Therapy Services for Stroke Patients[1]	met	not applicable	not met: with justification	not met: no justification	
Client's name: ____________; age: ________ record number: ________; date of review: ________ diagnosis: ____________; therapist: ________ ________________; reviewer: ________					
A. Referral Standards[2,3]					
1. The therapist documented:					
a. the date of receipt and referral source					
b. the services requested					
c. the above (a&b) within one working day of the referral receipt					
B. Evaluation Standards					
1. The initial evaluation was completed and the results documented within at least five working days after acknowledgement of referral receipt.					

---

1) The standards have been developed by occupational therapists working under the auspices of the AOTA Continuing Certification Program and the AOTA-HEW Continuing Competency Contract No. I-AH-44116. The standards are available for use in a self-assessment or peer review program; however, they are not official AOTA standards until approved by the AOTA Delegate Assembly. Any questions regarding their use should be directed to the AOTA Director of Certification.
2) The attached AOTA "Statement on Occupational Therapy Referral," is a guideline for referral for occupational therapy service.
3) The attached narrative statement on the standards and the glossary of terms should be used as a explanatory reference throughout the record review.
4) The standards are not PSRO screening criteria. AOTA model screening criteria are available for $2.00 from AOTA, Practice Division.

(January 1976 Edition)

DATA ABSTRACT FORM FOR RECORD REVIEW

Page 2 Stroke

COMMENTS:

COMMENTS:

	Standard was:			
	1 met	2 not applicable	3 not met: with justification	4 not met: no justification
2. The initial evaluation included an initial assessment of the client's goals, and functional abilities and deficits in:				
a. occupational performance (activities of daily living):				
1) self-care skills				
2) work skills				
3) play/leisure skills				
b. performance component skills:				
1) motor skills				
2) sensory-integrative skills				
3. When any of the above (2. a and/or b) evaluation results indicated possible deficits in: a. psychological skills, and/or b. social skills, and/or c. cognitive skills, the therapist evaluated these areas and documented functional deficits; or referred the client to the appropriate service/individual for evaluation.				
4. When any of the above (2. a, b and/or 3) evaluation results indicated the client's need for referral to community services or programs, the therapist determined the availability of such community resources; or refered the evaluation to the appropriate service/individual.				

DATA ABSTRACT FORM FOR RECORD REVIEW
Page 3 Stroke

COMMENTS:

COMMENTS:

	Standard was:			
	1 met	2 not applicable	3 not met: with justification	4 not met: no justification
C. Program Plan Standards				
1. When the evaluation results indicated any of the following problems, an occupational therapy program plan was developed:				
a. decreased ability for occupational performance (activities of daily living)				
b. muscle weakness and/or limited endurance				
c. limited passive range of motion				
d. lack of active motion				
e. abnormal muscle tone				
f. abnormal patterns of movement (synergies)				
g. lack of dexterity and/or coordination				
h. impaired sensation: (tactile, pain, temperature, stereognosis, proprioception)				
i. impaired cognitive functioning (confusion, disorientation, and/or judgment)				
j. impaired head or trunk control				
k. neglect of involved side of the body				
l. depression and/or low self-esteem				
m. pain				
n. inability to communicate basic needs				
o. edema of the hands				
p. visual field deficit				
q. apraxia				
2. The therapist documented the program plan within six working days after the acknowledgement of the referral receipt.				
3. The documented program plan consisted of a statement of:				
a. achievable program goals				
b. methods to achieve the goals				

DATA ABSTRACT FORM FOR RECORD REVIEW

page 4 Stroke

COMMENTS:

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS:
4. The program plan goals and methods were consistent with:					
a. the evaluative results and expected prognosis					
b. the goals of the client and/or family					
c. the program plans of other health care practitioners					
5. When the evaluation results indicated any of the following problems, the program plan consisted of (but need not be limited to) the following methods:					
a. decreased ability for activities of daily living: The therapist planned, as needed, to:					
1) treat specific performance components that interfere with function; and/or					
2) use repetitive practice of activities of daily living; and/or					
3) teach one-handed methods for performance of activities of daily living; and/or					
4) provide and train in the use of assistive devices; and/or					
5) develop pre-vocational or avocational interests; and/or					
6) give recommendations to eliminate and/or adapt architectural or environmental barriers to enhance performance in the discharge setting;					
b. muscle weakness and/or limited endurance where there is isolated muscle control: The therapist planned, as needed, to:					
1) use graded activity program; and/or					
2) use assistive to active to resistive exercise program; and/or					
3) use activities of daily living training program					

DATA ABSTRACT FORM FOR RECORD REVIEW
Page 5 Stroke

COMMENTS:

COMMENTS:

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification
c. limited passive joint range of motion:				
The therapist planned, as needed, to:				
1) teach self-range of motion; and/or				
2) use exercise devices, i.e. pulleys and skateboard; and/or	[redacted]	[redacted]	[redacted]	[redacted]
3) use positioning devices, i.e. splints, slings, pillow, arm rests, lapboards; and/or	[redacted]	[redacted]	[redacted]	[redacted]
4) use graded activity programs; and/or				
5) perform passive range of motion or teach significant others to do so				
d. lack of active motion in the involved extremity:				
The therapist planned to:				
1) use methods which facilitate motion				
e. abnormal muscle tone:				
The therapist planned, as needed, to:				
1) use methods which either facilitate or inhibit tone; and/or				
2) perform passive range of motion; and/or	[redacted]	[redacted]	[redacted]	[redacted]
3) refer to physician for medical management				
f. abnormal patterns of movement of the involved extremity (synergies):				
The therapist planned to:				
1) use methods to work through abnormal and facilitate normal patterns of movement				

DATA ABSTRACT FORM FOR RECORD REVIEW

page 6 Stroke

COMMENTS:

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS
g. lack of dexterity and/or coordination					
The therapist planned to:					
1) use repetitive graded activities or exercises requiring coordination.					
h. impaired sensation:					
The therapist planned to:					
1) use methods to compensate for sensory impairment					
i. confusion, disorientation, and/or poor judgment:					
The therapist planned to:					
1) use reality orientation techniques; and/or					
2) structure patient's daily activities or environment; and/or					
3) instruct significant others on approaches for patient management; and/or					
4) refer for medical management; and/or					
5) use sensory-integrative techniques to increase orientation to the environment					
j. impaired head or trunk control:					
The therapist planned to:					
1) use strengthening activities when weakness is identified as the cause; and/or					
2) use exercises/activities to enhance postural and equilibrium reactions and to increase awareness of body in space; and/or					
3) intermittently use equipment to challenge control; and/or					
4) provide support equipment as needed; and/or					
5) teach patient and/or significant others safety precautions					

DATA ABSTRACT FORM FOR RECORD REVIEW
Page 7 Stroke

COMMENTS:

COMMENTS:

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification
k. neglect of the involved side:				
The therapist planned, as needed, to:				
1) use sensory stimulation; cognitive input; and/or	[redacted]	[redacted]	[redacted]	[redacted]
2) use bilateral activities, especially those requiring crossing into neglected spaces; and/or	[redacted]		[redacted]	[redacted]
3) position body parts where they can be more easily seen and less easily ignored; and/or	[redacted]	[redacted]	[redacted]	
4) instruct significant others in the nature of the problem and safety precautions				
l. depression and/or low esteem:				
The therapist planned, as needed, to:				
1) encourage and provide opportunity for the expression of feelings	[redacted]	[redacted]	[redacted]	
2) involve the patient in success experiences	[redacted]		[redacted]	[redacted]
3) help patient recognize his/her capabilities	[redacted]	[redacted]	[redacted]	[redacted]
4) refer for medical or psychological management				
m. pain:				
The therapist planned, as needed, to:				
1) notify the physician	[redacted]	[redacted]	[redacted]	[redacted]
2) if any of the following are causes: increased muscle tone --------→ a) use techniques to decrease tone		[redacted]	[redacted]	[redacted]
unsupported joint ------------→ b) provide support	[redacted]	[redacted]	[redacted]	[redacted]
joint tightness ---------------→ c) perform range of motion	[redacted]	[redacted]	[redacted]	
edema ----------------------→ d) use positioning, active exercise and/or provide support	[redacted]	[redacted]	[redacted]	[redacted]

COMMENTS:

DATA ABSTRACT FORM FOR RECORD REVIEW
Page 8 Stroke

COMMENTS:

COMMENTS:

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification
n. inability to communicate basic needs:				
The therapist planned, as needed, to:				
1) explore alternate methods of communication (exploration may mean referral to or collaboration with speech pathologist)				
o. edema of the hand:				
The therapist planned, as needed, to:				
1) elevate the hand; and/or				
2) apply pressure wrap; and/or				
3) refer for medical management				
p. visual field deficit:				
The therapist planned, as needed, to:				
1) teach patient to scan				
2) increase cognitive awareness of the problem	[redacted]	[redacted]	[redacted]	[redacted]
3) use activities that require working in the impaired visual field	[redacted]	[redacted]	[redacted]	[redacted]
4) instruct significant others on management of the problem				
q. apraxia:				
The therapist planned, as needed, to:				
1) use activity programs graded by cognitive requirements	[redacted]	[redacted]	[redacted]	[redacted]
2) use repetitive practice of similar motor acts using different objects	[redacted]	[redacted]	[redacted]	[redacted]
3) use graded, repetitive, manual guidance for handling and use of familiar objects	[redacted]	[redacted]	[redacted]	[redacted]
4) increase the complexity of functional performance as simpler tasks are mastered	[redacted]	[redacted]	[redacted]	[redacted]
5) use sensory-integrative techniques	[redacted]	[redacted]	[redacted]	[redacted]

DATA ABSTRACT FORM FOR RECORD REVIEW
Page 9 Stroke

	Standard was:				
	1	2	3	4	COMMENTS:
COMMENTS:	met	not applicable	not met: with justification	not met: no justification	

D. Program Implementation Standards

1. The therapist implemented the occupational therapy program according to the program plan. (refer back to the program plan goals and methods)

2. The therapist documented at least every five working days, the occupational therapy services provided, the frequency of the services, and the client's progress toward goals.

3. The therapist periodically re-evaluated and documented the changes in the client's occupational performance and/or performance component skills.

   a. if the client's program exceeded a 3-month period, the client was re-evaluated at least every two months. [redacted]

   b. if the client's program is less than three months, the client was re-evaluated at least once per month. [redacted]

4. The therapist formulated, documented and implemented program changes consistent with the changes in the client's occupational performance and performance component skills.

E. Discharge Standards

1. The therapist prepared and documented the occupational therapy discharge plan. [redacted]

2. The discharge plan was consistent with the client's goals, functional abilities and deficits, community resources, and prognosis.

DATA ABSTRACT FORM FOR RECORD REVIEW
Page 10 Stroke

COMMENTS:

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS
3. The discharge plan was consistent with the discharge plans of the other health care practitioners.					
4. In the preparation of the discharge plan, the therapist allowed enough time for coordination, acceptance, and effective implementation of the discharge plan.					
5. The therapist documented within two days following discharge, the client's functional abilities and deficits in occupational performance and performance component skills at the time of discharge.					
6. The therapist recommended discontinuation of occupational therapy services when the client achieved the program goals and/or achieved maximum benefit from the services.					

January 1976

American Occupational Therapy Association, Inc.

DATA ABSTRACT FORM FOR RECORD REVIEW	Standard was: 1 met	 2 not applicable	 3 not met: with justification	 4 not met: no justification	COMMENTS
Standards of Practice for Occupational Therapy Services for Clients with Arthritis[1]					
Client's name: ____________; age: ________ record number: ________; date of review: ________ diagnosis: ____________; therapist: ________ ________________; reviewer: ________					
Process Standards					
A. Referral Standards[2,3]					
1. The therapist documented:					
a. the date of receipt and referral source b. the services requested c. the above (a&b) within one working day of the receipt of the referral					
B. Evaluation Standards					
1. The evaluation was completed and the results documented within at least five working days after acknowledgement of referral receipt.					

---

1) The standards have been developed by occupational therapists working under the auspices of the AOTA Continuing Certification Program and the AOTA-HEW Continuing Competency Contract No. I-AH-44116. The standards are available for use in a self-assessment or peer review program; however, they are not official AOTA standards until approved by the AOTA Delegate Assembly. Any questions regarding their use should be directed to the AOTA Director of Certification.

2) The attached AOTA "Statement on Occupational Therapy Referral," is a guideline for referral for occupational therapy service.

3) The attached narrative statement on the standards and the glossary of terms should be used as a explanatory reference throughout the record review.

4) The standards are not PSRO screening criteria. AOTA model screening criteria are available for $2.00 from AOTA, Practice Division.

(January 1976 Edition)

DATA ABSTRACT FORM FOR RECORD REVIEW
page 2 - Arthritis Process Standards

Standard was:
1 met
2 not applicable
3 not met: with justification
4 not met: no justification

COMMENTS·

COMMENTS:

2. The evaluation included (but need not be limited to) an initial assessment of the client's goals, and functional abilities and deficits in:

   a. occupational performance (activities of daily living):
      1) self-care skills
      2) work skills
      3) play/leisure skills

   b. performance components:
      1) motor skills:
         a) active and passive range of motion of affected joints;
         b) muscle strength (within pain-free ROM)
         c) endurance; level of activity tolerance

3. The evaluation also included (but need not be limited to) an initial assessment of:

   a. the client's ability to utilize the physical facilities and equipment within the living and/or working enviornment

4. If any of the above (2 and/or 3) evaluation results indicated the client's need for referral to community services or programs, the therapist determined the availability of such community resources; or referred the evaluation to the appropriate service/individual.

5. If any of the above (2,3,4) evaluation results indicated possible deficits in psychological or social skills, the therapist evaluated and documented functional deficit in psychological or social skills; or referred the client to the appropriate service/individual for evaluation.

DATA ABSTRACT FORM FOR RECORD REVIEW
page 3 Arthritis Process Standards

COMMENTS:

Standard was:

COMMENTS:

	1 met	2 not applicable	3 not met: with justification	4 not met: no justification
C. Program Plan Standards				
1. The therapist documented the program plan within six working days after the acknowledgement of the referral receipt.				
2. The documented program plan consisted of a statement of:				
a. achievable program goals				
b. methods to achieve the goals				
3. The program plan goals and methods were consistent with:				
a. the evaluative results and expected prognosis				
b. the goals of the client and/or family				
c. the program plans of other health care practitioners				
4. When the evaluation results indicated a problem in any of the following areas and if there were no medical restrictions, the program plan included (but need not be limited to) the following methods:				
a. occupational performance (activities of daily living): The therapist planned, as needed, to:				
1) teach adaptation of methods; and/or				
2) provide adapted or assistive equipment; and/or				
3) adapt equipment and/or environment; and/or				
4) discuss alternative methods of pursuing former vocational and avocational activities; and/or				
5) discuss and develop new avocational interests and skills which are satisfying to client's needs and are not harmful to affected joints; and/or				
6) discuss the effect of the disease on the client's ability to perform activities of daily living				

DATA ABSTRACT FORM FOR RECORD REVIEW

page 4 Arthritis Process Standards

	Standard was:				COMMENTS:
	1	2	3	4	
	met	not applicable	not met: with justification	not met: no justification	

COMMENTS:

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b. motor skills:

The therapist planned, as needed, to:

1) provide instruction in kinetic activities designed to increase and/or maintain passive and active range of motion; and/or
2) design, fabricate and/or fit orthotic devices as approved by physician; or recommend the design of orthotic devices to be constructed by another specialist; instruct the client in the rationale for the orthotic device; the use and care of the device; precautions to be observed; and/or
3) instruct the client in general principles of joint protection:
   a) proper body mechanics
   b) avoidance of static and/or deforming postures
   c) work simplification techniques
   d) need for proper balance of rest and activity

c. problem in the use of community resources:

The therapist planned, as needed, to:

1) discuss with the client those community resources which are available to meet his or her needs in the areas of: employment, recreation, socialization, transportation, additional therapy services, and/or sources for adaptive and/or exercise equipment.

DATA ABSTRACT FORM FOR RECORD REVIEW
page 5 Arthritis Process Standards

Standard was:

1	2	3	4
met	not applicable	not met: with justification	not met: no justification

COMMENTS:

COMMENTS:

d. problem in psychological skills:

The therapist planned, as needed, to:

1) provide psychological support; and/or
2) provide opportunities for client to express feelings; and/or
3) develop self esteem and self concept

e. need for home program:

The therapist planned, as needed, to:

1) develop, discuss and document a home program

D. Program Implementation Standards

1. The therapist implemented the occupational therapy program according to the program plan developed for the following problem areas:

   a. problem in occupational performance (activities of daily living)
   b. problem in motor skills
   c. problem in the use of community resources
   d. problem in psychological skills
   e. need for home program

   (refer back to documented program plan for review of program plan goals and methods)

2. The therapist documented at least every five working days, the occupational therapy services provided, the frequency of the services, and the client's progress toward goals.

DATA ABSTRACT FORM FOR RECORD REVIEW
page 6 Arthritis Process Standards

Standard was:			
1	2	3	4
met	not applicable	not met: with justification	not met: no justification

COMMENTS:

COMMENTS:

3. The therapist documented the following symptoms, (or changes in symptoms) if noted:

   a. joint swelling, tenderness, inflammation
   b. pain
   c. stiffness
   d. muscle tenderness and atrophy
   e. skin changes; nodules
   f. increased joint deformity
   g. decreased sensation

4. The therapist periodically re-evaluated and documented the changes in the client's occupational performance and/or performance component skills:

   a. if the client's program exceeded a three-month period, the client was re-evaluated at least every two months
   b. if the client's program was less than three months, the client was re-evaluated at least once per month

5. The therapist forumulated, documented, and implemented program changes consistent with the changes in the client's occupational performance and performance component skills.

E. Discharge Standards

1. The therapist prepared and documented the occupational therapy discharge plan.

2. The discharge plan was consistent with the client's goals, functional abilities, deficits, community resources, and prognosis.

DATA ABSTRACT FORM FOR RECORD REVIEW

page 7 Arthritis Process Standards

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS:
COMMENTS:					
3. The discharge plan was consistent with the discharge plans of the other health care practitioners.					
4. In the preparation of the discharge plan, the therapist allowed enough time for coordination, acceptance, and effective implementation of the discharge plan.					
5. The therapist documented within two days following discharge, the client's functional abilities and deficits in occupational performance and performance component skills at the time of discharge.					
6. The therapist recommended discontinuation of occupational therapy services when the client achieved the program goals and/or had achieved maximum benefit from the services.					

January 1976

American Occupational Therapy Association, Inc.

DATA ABSTRACT FORM FOR RECORD REVIEW	Standard was: 1	2	3	4	COMMENTS:
Standards of Practice for Occupational Therapy Services for Clients with Arthritis [1]	met	not applicable	not met: with justification	not met: no justification	

Client's name:________________; age:__________

record number:__________; date of review:__________

diagnosis:________________; therapist:__________

______________________; reviewer:__________

Outcome Standards [2, 3]

A. General Standards:

These general standards are applicable to clients with any type of arthritis. Additional outcome standards are stated for some specific forms of arthritis.

Outcome standards state what the client is expected to achieve or be able to do as a result of the occupational therapy program.

In order to assess an occupational therapy program with these outcome standards, the reviewer should review the record/chart to determine if the client achieved each of the following goals:

1. The client performs, within the limitation of the disability, those activities of daily living which are performed by someone of his/her age and role.

---

1) The standards have been developed by occupational therapists working under the auspices of the AOTA Continuing Certification Program and the AOTA-HEW Continuing Competency Contract No. 1-AH-44116. The standards are available for use in a self-assessment or peer review program; however, they are not official AOTA standards until approved by the AOTA Delegate Assembly. Any questions regarding their use should be directed to the AOTA Director of Certification.
2) The attached AOTA "Statement on Occupational Therapy Referral," is a guideline for referral for occupational therapy service.
3) The attached narrative statement on the standards and the glossary of terms should be used as a explanatory reference throughout the record review.
4) The standards are not PSRO screening criteria. AOTA model screening criteria are available for $2.00 from AOTA, Practice Division.

(January 1976 Edition)

DATA ABSTRACT FORM FOR RECORD REVIEW

page 2 Arthritis Outcome Standards

COMMENTS:

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS:
2. The client practices a balance of rest and activity, work simplification techniques for energy conservation in his or her daily routine or activities.					
3. The client incorporates joint protection/preservation techniques into his or her daily routine.					
4. The client uses proper body mechanics during rest and/or activity.					
5. The client performs kinetic activities as instructed; observes necessary precautions.					
6. The client has same or increased active and passive range of motion and strength on last day treated as on first day measured.					
7. The orthotic device met the needs for which it was provided; e.g. decrease of pain, increase of function, and/or prevention of deformity.					
8. The client properly uses the orthotic device, and observes precautions.					
9. The client properly applies, removes, and cares for the orthotic device.					
10. The client correctly uses the adapted or assistive device.					
11. Modification in the structural arrangement and/or equipment in the client's environment has increased the client's ability to function in the environment.					
12. The client correctly follows the home program.					
13. The client's family encourages the client to follow the instructions of the occupational therapy program, the home program, and the required activity restrictions.					

DATA ABSTRACT FORM FOR RECORD REVIEW

page 3 Arthritis Outcome Standards

COMMENTS:

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS:
14. The client and/or significant others agree to follow the arrangements made to assist the client in activities he or she is unable to perform at discharge.					
B. Outcome Standards for the Post-Surgical Phase:					
Standards are the same as those listed under the general standards with the following additions:					
1. Pre-operatively, the client correctly performs the pre-operative exercises.					
2. Post-operatively, the client correctly performs the post-operative exercises; and/or correctly uses orthotic devices.					
3. Client observes post-operative positioning, exercise and activity precautions, including correct body alignment while lying, sitting, ambulating, or transferring.					
4. During surgical post-operative recovery period, the client functions at maximum level of independence in activities of daily living, and receives assistance for those activities and/or tasks he or she is unable to perform.					
5. Client's family or significant others encourages the clients to follow the instructions of the occupational therapy program and activity restrictions specific to the surgical procedure.					

DATA ABSTRACT FORM FOR RECORD REVIEW
page 4 Arthritis Outcome Standards

	Standard was: 1 met	2 not applicable	3 not met: with justification	4 not met: no justification	COMMENTS:
COMMENTS:					
C. Outcome Standards for Clients with Systemic Manifestations of Rheumatoid Arthritis:					
1. Standards are the same as those listed under the general standards with the following additions:					
a. Client observes in his or her daily routine, the safety and/or activity precautions relative to systemic involvement (gastro-intestinal, renal, cardic, pulmonary, or visual complications).					
D. Outcome Standards for Clients with Polymyositis and Dermatomyositis:					
1. Outcome standards for treatment of manifestations of joint involvement and/or arthralgic are the same as the general standards.					
2. Outcome standards for clients with muscle involvement are the same as the general standards with the following additions:					
a. Client uses prescribed ambulation aids consistently and as instructed, observing safety precautions against falling during ambulation and transfer.					
b. When there is dysphagia secondary to esophageal involvement, client observes or can instruct others in necessary safety precautions relative to eating.					
c. Client observes appropriate positioning while lying or sitting, including use of neck supports while sitting.					
d. Client performs daily strengthening exercises as prescribed.					
e. Client performs range-of-motion exercises daily, as instructed.					

DATA ABSTRACT FORM FOR RECORD REVIEW

page 5 Arthritis Outcome Standards

Standard was:			
1	2	3	4
met	not applicable	not met: with justification	not met: no justification

COMMENTS:

COMMENTS:

E. Outcome Standards for Clients with Articular and/or Systemic Manifestations of Juvenile Rheumatoid Arthritis:

1. Standards are the same as the general standards with the following additions:

   a. The child, parents and/or responsible others observes in his or her daily routine, the safety and/or activity precautions , related to systemic involvement (gastro-intestinal, renal, cardiac, pulmonary or visual complications).

   b. The parents or responsible others use treatment techniques and supervise treatment follow-through when client is unable to independently manage a home program.

   c. The client's parents and/or others use appropriate activities for the child's developmental level to prevent or compensate for developmental lag attributed to illness.

F. Outcome Standards for Clients with Ankylosing Spondylitis:

1. Standards are the same as the general standards with the following additions:

   a. Client practices a balance of rest and activity, and takes safety precautions against falling, bending or stooping.

   b. Client observes in his/her daily routine the safety and/or activity precautions relative to systemic involvement (gastro-intestinal, renal, cardiac, pulmonary, or visual complications).

   c. Client performs exercise program and maintains optimal posture as instructed.

   d. Client performs postural and breathing exercises as instructed.

DATA ABSTRACT FORM FOR RECORD REVIEW

page 6 Arthritis Outcome Standards

Standard was:			
1	2	3	4
met	not applicable	not met: with justification	not met: no justification

COMMENTS:

COMMENTS:

G. Outcome Standards for Clients with Systemic Lupus Erythematosis:

1. Standards for articular involvement are the same as the general standards, with the following additions:

   a. Client observes in his/her daily routine, the safety and/or activity precautions relative to systemic involvement (gastro-intestinal, renal, cardiac, pulmonary or visual complications).

   b. Clients who are sensitive to ultra-violet or sunlight use protective techniques to avoid exacerbating effects.

H. Outcome Standards for Clients with Progressive Systemic Sclerosis:

1. Standards for articular involvement are the same as the general standards, with the following additions:

   a. Client observes in his/her daily routine, the safety and/or activity precautions relative to systemic involvement (gastro-intestinal, renal, cardiac, pulmonary or visual complications).

   b. Client performs daily range-of-motion exercises (including deep breathing to maintain chest expansion), and facial exercises to preserve oral opening.

   c. Client's family and significant others pay specific attention to dental care.

   d. When necessary, the client observes precautions for Raynaud's phenomenon and skin ulcerations.

APPENDIX X1

KNOWLEDGE AND SKILLS REQUIRED OF AN ADVANCED LEVEL OCCUPATIONAL THERAPIST PRACTICING WITHIN THE SPECIALITY AREA OF MENTAL HEALTH

APPENDIX X1

KNOWLEDGE AND SKILLS REQUIRED OF AN ADVANCED LEVEL OCCUPATIONAL THERAPIST PRACTICING WITHIN THE SPECIALITY AREA OF MENTAL HEALTH

KNOWLEDGE AND SKILLS REQUIRED OF AN ADVANCED LEVEL OCCUPATIONAL THERAPIST PRACTICING WITHIN THE SPECIALITY AREA OF MENTAL HEALTH

Definition of an Occupational Therapy Mental Health Specialist

The occupational therapy mental health specialist is an individual who possesses advanced knowledge and skills and has either a basic professional degree with a minimum of two years of supervised clinical experience in the field of mental health or a second professional degree with u minimum of one year of supervised clinical experience in the field of mental health.

The specialized knowledge required by an occupational therapy mental health practitioner includes: normal emotional growth and development, abnormal psychology, clinical psychiatric conditions, neurophysiology and neuroanatomy, and sociology. Knowledge of theoretical principles of occupational therapy practice and the technqiues of activity intervention are also required. This same knowledge base is expected of the entry-level occupational therapist; the specialist, however, must be able to expand upon this content in both scope and depth.

The specific functions of an advanced level occupational therapist are the same as the functions of an entry level therapist. The functions with individual and/or groups of patients/clients are: (1) screening-evaluation, (2) treatment of program planning, and (3) treatment or program implementation.

The supportive functions for both groups often include administration, such as management of staff, budget, and supplies, and participation in research. More frequently, the advanced level therapist is responsible for student supervision, research, in-service education and consultation. The knowledge and skills requisite to these support services are not dealt with in this document. Oftentimes, and perhaps erroneously so, the advanced level therapist is defined by his/her participation in supportive services, i.e., supervision and administration.

Knowledge Requisite to Occupational Therapy Mental Health Speciality Practice

The advanced level occupational therapy mental health practitioner must know:

1. occupational therapy theories: The therapist must know the major occupational therapy theories and have a complete understanding of the writings of major theorists including Gail S. Fidler, OTR, Mary Reilly, Ed.D., OTR, and Anne C. Mosey, Ph.D., OTR. The therapist also should be versed in the concept of occupational performance and Robert White's theory of competency.

2. application of theory: The therapist must know principles of application of theory and must know how to generalize theory to specific client intervention.

3. use of activities: The therapist must know about the use of activities in assessing and treating patients/clients. The therapist must also know the meaning and effects of specific activities and know how to analyze and use them.

4. psychiatric conditions: The therapist must have a thorough understanding of the processes of emotional disorders. The therapist should also know the diagnostic categories and implications of the somatic treatment indicated. The therapist should know how to obtain information from the literature and from colleagues regarding psychiatric conditions. Knowledge of the organic bases of certain conditions is also required.

5. social factors: The therapist must have knowledge of the social environment of his/her patients/clients and must be knowledgeable about the activities and values important to particular cultures and the psychiatric conditions specific to it. The therapist must also be able to know how to study different and changing cultures and how to apply occupational therapy theories to them.

Skills of an Occupational Therapy Mental Health Specialist

1. general skills: The advanced level therapist differs from an entry level therapist in a qualitative manner. Although both are likely to have the same knowledge base, the advanced level therapist should be able to apply that knowledge more readily. In all aspects of mental health practice, the specialist should be able to better predict the outcomes of practice. Whereas the entry level therapist is likely to use trial and error, the advanced level therapist can approach the patient/client with greater certainty. It is indeed, therefore, difficult to quantify these differences.

2. specific skills: The advanced level therapist must be able to:
   a. readily observe and define normal and abnormal behavior and assess functional capabilities of the patients/clients within a given population.
   b. readily use and design a method of measuring relative degrees of functional behavior.
   c. analyze and report information regarding patient/client functioning.
   d. select, plan for and predict the effects of therapeutic intervention.
   e. use a variety of activities and orient patients/clients to the activity process.
   f. modify treatment programs.

KNOWLEDGE AND SKILLS TO ACCOMPANY ROLE & FUNCTIONS

(See Appendix V, The Role and Function of an Occupational Therapist as a Mental Health Practitioner)

<table>
<tr><th>FUNCTION:</th><th>Screening-Evaluation</th><th>Treatment Program Planning</th><th>Treatment of Program Implementation</th></tr>
<tr><td>KNOWLEDGE:
General knowledge (applies to all functions)</td><td colspan="3">1. Normal human behavior. This is theoretical knowledge since human behavior is described in a number of different ways. It is expected that the therapist understands several different theories regarding normal human behavior.
2. Pathological conditions or deviations in normal human behavior and standard nomenclature used to describe such conditions.
3. Treatment theories-hypotheses regarding behavioral change. Therapist should be familiar with several different treatment theories.
4. Social and cultural environment and its effect upon normal and deviant behavior. The nature of individual's and group's engagement in activities.
5. Occupational therapy theories/hypotheses regarding use of activity to facilitate behavioral change.</td></tr>
<tr><td>Specific knowledge (applies as indicated)</td><td>Test and measurement
Design and administration of evaluation instruments</td><td>Syntheses of evaluation data
Social factors</td><td>Use and analysis of activities
How specific activity changes behavior</td></tr>
<tr><td>SKILLS:</td><td>The ability to:
● observe and define normal and deviant behavior
● design a test of measurement to assess client's behavior
● administer evaluative tool
● collect and report information</td><td>The ability to:
● assess client's potential
● select and predict effects of therapeutic intervention</td><td>The ability to:
● instruct client in activity
● select and engage client in an activity that will provide a change in client's behavior</td></tr>
</table>

APPENDIX B

THE ROLE AND FUNCTIONS OF THE OCCUPATIONAL THERAPIST AS A MENTAL HEALTH PRACTITIONER

THE ROLE AND FUNCTIONS OF THE OCCUPATIONAL THERAPIST AS A MENTAL HEALTH PRACTITIONER

BY DIANE SHAPIRO, M.A., OTR
PRINCIPAL INVESTIGATOR

General Definition of Occupational Therapy[1]

Occupational therapy as an applied science is concerned with directing man's participation in selected tasks to restore and enhance performance, to facilitate learning of tasks identified as essential for adaptation and productivity, to minimize pathology and to promote the maintenance of health. Its fundamental objective is the development and maintenance of the capacity throughout the life span, to perform with satisfaction to self and others, those tasks and roles essential to productive living.

Reference to occupation in the title is in the context of man's goal- directed use of time, energy, interest and attention.

The Role and Function of the Occupational Therapist as a Mental Health Practitioner

The specific roles and functions of an occupational therapist as a mental health practitioner with individual or groups of clients are related to: (1) screening-evaluation, (2) treatment or program planning and (3) treatment or program implementation. Secondary or supportive roles and functions may include education and supervision of students or technical staff, administration, research and consultation.

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[1] From Occupational Therapy: Its Definition and Functions, AOTA 1972.

The scope of the role of the occupational therapist which is described in this document is limited to the occupational therapist working with adult clients.

The clients are individuals who have demonstrated difficulty in management of their life tasks because of any number of factors caused by either emotional and/or environmental stress or pathology. Clients of all ages receive the services of the occupational therapist, however, referrals come from other professionals, relatives, or directly from clients. Services are offered in acute or long-term private or public hospitals, psychiatric clinics, schools, community mental health programs, clients' homes or private practice setting.

1. Evaluation

The first phase of occupational therapy intervention is screening and evaluation of task performance, i.e., the performance of self-care, work and play tasks, the activities of daily living. The therapist begins the screening process by making a generalized assumption about whether the client needs some kind of treatment. Observation of client, and/or family interview, and a referral often indicate broad areas of dysfunction. During the screening phase, the therapist, for example, may ask the client to describe his/her normal daily activities. A poor balance of work and play experiences would be indicative of the need for evaluation. In all cases, the screening is focused upon observation of the client performing an activity and/or an interview with client and/or family about the client's ability to perform within his or her occupational and supportive roles. The therapist must decide from this cursory information whether or not the client can participate in a thorough evaluative procedure or if a postponement is necessary. A frequent contraindication for evaluation may be an acute psychotic state. At such times, medication and supportive diversional activities are recommended.[2] The performance of an individual in a highly agitated state may not be indicative of his or her actual ability to perform.

If the client is able to participate in the evaluation, the therapist must select the appropriate procedures. In some facilities, all clients are evaluated with the same procedures. In others, the therapist will select one based upon the client's specific needs and/or presenting symptoms. The evaluation procedure, often designed by the therapist, is an actual activity-oriented test situation. For example, an evaluation battery may include a craft project (with written and/or oral directions), a typing test, a group project (several clients sharing a task) and one or more commercially available tests.

The therapist would assign simulated tasks or actual activities and observe the client's performance in each area. Once the evaluation is completed, and the client's task abilities and limitations have been identified, the therapist would decide upon the causes of limitation in terms of skill deficits. Additional or more finite evaluation in skill areas such as perceptual-sensory integrative skills, cognitive skills, intrapersonal and interactional skills, and physical motor skills, may be indicated. For example, if the client was unable to perform the tasks that were dependent upon perceptual-sensory-integrative skills, standardized tests of perceptual-sensory integrative skills may be administered. All areas of causative factors are explored by further evaluation with possible referral to specialist, i.e., neurologist, opthamologist, or psychologist; visit to home,or interview with family members.

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[2] These instances are likely to occur in inpatient programs, but are less likely encountered in outpatient or community programs.

A report of findings including all abilities, limitations, environmental conditions and assumptions regarding the nature of the cause is prepared for presentation to colleagues, supervisor and client.

11. Treatment or Program Planning

The second stage of intervention, treatment or program planning, consists of organizing a comprehensive method of helping the client to correct deficient skills, acquire new skills and change defined environmental obstacles.

The process of planning must account for the client's aspiring and actual occupational role, developmental stage, socioeconomic status, length of treatment time and motiviation for change.[3]

Priorities for selection of skill integration are chosen collaboratively by the client, therapist and other professionals. The selection may be based upon a developmental sequence (defined, for example, by Piaget or Erikson) or upon an immediate identified need such as the care of a child or personal hygiene.

Environmental factors are also considered in the selection of priorities. A change in the environment, either physical or personal, may incorporate the use of existing abilities. An out-patient, for example, may be distressed because of an inability to cope with a job assignment. A change in job task may maximize a specific ability.

The treatment program planning report includes all recommendations for change (goals), the specific therapeutic techniques to be used, the estimated length of time, the financial implications, the therapist's judgement regarding prognosis, and plans for after or continuing care.

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[3] Dealing with client's motivation is a difficult issue. Amotivational syndromes are frequently associated with emotional disorders and is possibly a primary factor of unsuccessful treatment in mental health. Occupational therapists usually try to encourage motivation for change by presenting programs that lead to gentle and rather rapid change in areas that are "nonthreatening" to the client. Before any major change can be tolerated, the client must accept the need for and the often painful process of change.

111. Treatment - Program Implementation

The assumptions about how change in human behavior occurs are the basis of the techniques chosen for occupational therapy intervention. Occupational therapists ascribe to various different theoretical principles regarding the manner in which the activity process changes behavior. The implementation of a therapeutic program or specific technique is dependent upon the chosen theoretical perspective.

The following three examples will illustrate three different theoretical approaches and use of techniques.

1. A 45 year-old male accountant, recently unemployed because of his company's bankruptcy, has a second "psychotic depression". He was discharged from an in-patient service, is on medication, and was referred to out-patient occupational therapy by his psychiatrist. Ability to concentrate, attend to a task and sustain performance are his major strengths. His despair, most evidenced by a slovenly appearance, considerable weight loss and lack of motivation are factors most detrimental to his present functioning. Employment is identified by client and wife as an immediate need.

   The therapist in consultation with a dietitian could discuss recommendations for a diet and develop a behavior modification program to reinforce[4] proper eating habits. The wife can assist in the administration of positive reinforcement following self-care and grooming behaviors. As his appearance improves, the therapist can begin role-playing techniques as simulated job interview experiences and then refer the client to a vocational counselor or a placement bureau.

A supportive program to maintain the client's strengths would concurrently be assigned. Those activities or hobbies that interest him as well as require concentration and attention would be offered.

2. A 29 year-old female high school graduate with a long standing history of schizophrenia, repeated hospitalizations, and unemployment, is an inpatient in a state hospital. Her major strengths are compliance and willingness to cooperate. She functions at a very low developmental level and has never been able to successfully complete a task other than simple craft projects. Her posture is poor; she has a shuffling gait, weakened muscle tone, absent eye contact and poor motor coordination. Sensory integrative techniques as described by

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[4] Specific reinforcers are selected by the client- praise, tokens and coffee-breaks are some examples.

Lorna Jean King, OTR, are prescribed.[5]

Techniques that provide vestibular stimulation, such as rolling and spinning exercises are implemented. These activities can be offered in a group or individually.

3. A 18 year-old male was referred to an out-patient clinic by the school psychologist because of a two-year history of amphetamine abuse, truancy and poor conduct in class. His grades were high in English, average in other subjects and failing in mathematics and physical education. Patient's parents report delayed developmental landmarks and general clumsiness as compared to siblings.

The symptom of drug abuse, in this case may be best handled by the psychiatrist. The occupational therapist would select activities based upon the defined developmental sequence of perceptual sensory integrative skills of A. Jean Ayres[6] and Newell Kephart[7]. Skill in perceptual sensory integrative performance would be likely to help him attend to the structure of school and authority and may lessen his need for antisocial behavior.

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[5] Lorna Jean King, "A Sensory Integrative Approach to Schizophrenia," AJOT. Vol. 28, No. 9, October 1974.

[6] A. Jean Ayres, "The Development of Perceptual-Motor Abilities: A Theoretical Basis for Treatment of Dysfunction", The Development of Sensory Integrative Theory and Practice. Kendall/Hunt Publications, Inc., Dubuque, Iowa, 1974.

[7] Newell Kephart, Slow Learner in the Classroom. Charles C. Merrill, Ohio 1960.

Concurrently, activities that incorporate his verbal skills such as debate groups and acting classes, would be assigned.

The occupational therapist may not be the person responsible for administration of all activities. Often an occupational therapy assistant or recreational therapist helps implement the program. The occupational therapist is usually in charge of planning, selecting and assigning the particular programs or groups.

In many facilities the occupational therapist functions as the coordinator of clients' activities. This requires that the therapist in addition to direct intervention, assign the client (if this is indicated) to a schedule of daily experiences. The client's treatment schedule is coordinated with other disciplines and services and/or the family, if the client is living outside of the treatment facility. The schedule changes during each phase of intervention. During screening-evaluation and planning, the purpose of the total schedule is diagnosis and orientation. Initially during treatment-program intervention, the schedule is focused upon therapeutic activities such as acquisition of skills. Later it is focused upon transition away from the treatment facility. Often activities outside of the facility such as employment, membership in the "Y" and time with the family are assigned so that the client can gradually adjust to the normal demands of independent adult life.

IV. Reevaluation and Termination

Reevaluation of the client and the course of treatment are considered throughout the program. Recommendations for changes are made accordingly.

Ideally, the termination of treatment is recommended upon achievement of goals. Reimbursement policies, facility requirements and client's motivation are often factors that influence the point of termination. These factors are identified early so that plans can consider them.

This document was prepared under the auspices of the AOTA-HEW Continuing Competency Contract #NO1-AH-44116. The document was prepared as a frame of reference for the development of standards of practice for occupational therapy services in a mental health program. The document was prepared solely for the purpose of this contract and is not an officially approved AOTA document at this time.

January 1976

APPENDIX X11

A Self-Study Program
for the Occupational Therapist
as a Mental Health Practitioner

A SELF-STUDY PROGRAM

The Occupational Therapist as a Mental Health Practitioner

Prepared By

The American Occupational Therapy Association
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Project Supported By

Department of Health, Education, and Welfare
Division of Associated Health Professions
Manpower Utilization Branch

Contract # NO1-AH-44116

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Appendix A

  The Case-Study Self-Assessment Instrument

  Follow-up Materials

Appendix B

  Role and Functions of an Occupational Therapist as a Mental Health Practitioner

ACKNOWLEDGEMENTS

The task force members: Susan B. Fine, MA, OTR, Deanne McCraith, OTR, Shirley Zurchauer, MA, OTR, and Diane Shapiro, MA, OTR, Principal Investigator of Part II of the Continuing Competency contract, proposed and designed these study materials. Nancy O. Anderson, MA, OTR, participated in the early planning of the project.

The task force members and Project Staff sincerely thank Robert Conant, Ph.D., Chief, Manpower Utilization Branch, Division of Associated Health Professions, DHEW, for his support, guidance, and understanding during the contract time. Madelaine Gray, MA, OTR, Project Director, was extremely helpful. Her supervision and ideas were invaluable and very much appreciated.

A. Introduction

This self-study program is part of a continuing education project supported by the Department of Health, Education and Welfare and developed by the American Occupational Therapy Association, Inc., in fulfillment of the Continuing Competency contract. The continuing education part of the contract began in January 1975 and was completed August 1976. A complete description of the Continuing Competency contract is available from the AOTA national office.

Prior to the development of this self-study program, a case-study self-assessment instrument was mailed to 200 occupational therapists in the northeastern region of the country. All of the sampled therapists had identified themselves (via the 1973 AOTA Data Questionnaire) as working primarily in the area of mental health. A copy of the instrument and follow-up response material are in Appendix A of this booklet.

Following analysis of the completed assessments and consideration of reports from the AOTA Mental Health task force, the task force members decided upon the format and content for this study material. The Project Staff and task force members developed a tape cassette program designed to address two areas of concern: 1. clarification of the role of the occupational therapist as a mental health practitioner, and , 2. refinement of patient/client evaluation processes.

The 100 minute tapes are divided into two parts. The first part is a simulated team conference. The patient case is presented by a psychiatrist, occupational therapist, social worker and nurse. The case is actual and was altered only to disguise identity. The occupational therapist's report is unusually long; this was done deliberately to include a thorough report. All other reports are summarized.

The second part of the tape is an actual, spontaneous peer supervision session that took place several weeks after the team conference. The tape includes the occupational therapist's presentation of the problems that occurred during the course of the patient's treatment.

Included in this booklet are the materials used for evaluation for this patient and the therapist's written report. "The Role and Function of an Occupational Therapist as a Mental Health Practitioner" (Appendix B) was prepared by the task force members prior to the development of the taped program. The statement was used as a guide for the self-study program.

The task force members realize that facilities and therapists differ in theoretical approaches. Theory was intentionally not addressed in this program but will be included in subsequent programs. It is hoped that through the use of this and other continuing education programs, refinements can be made in our practice in mental health.

B. Instructions for use of Taped Programs

1. Complete the pre-study self-assessment
2. Listen to the total taped program. It may be helpful to stop the tape periodically to refer to the evaluation protocol, pages 6 - 15.
3. Review and study the evaluation protocols and materials in Appendices A and B*
4. Complete the post-study self-assessment
5. Complete the evaluation of self study program

It may be helpful to use this program as a part of a study or special interest group, a classroom activity or a task for a group-peer supervision session. It is strongly advised that the pre and post study assessments be used by all participants.

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* The order of items 2 & 3 may be reversed. Some learners attend to tapes more efficiently if they have first studied the written material.

C. Pre Study Section

Prior to listening to the tapes and studying the written material, take the time to respond to the items below. This self-study package is designed to help you to clarify your role as an occupational therapist through the demonstration of a model. It was also designed to present a complete patient evaluation to you.

By responding to these items before you study and then the other set of items afterward, you should be able to assess your own needs for further study and recommend content for the development of future self-study programs.

1. Describe the occupational therapist's role in a mental health facility.
2. Identify and define three (or more) critical functions of an occupational therapist in a mental health facility.
3. Describe the patient/client evaluation instruments you use to assess patient/client function.
4. Given a specific patient/client (select one you have worked with), plan an ideal treatment program based upon your evaluative findings.
5. Hypothesize the outcome of the above treatment program.

6. List specific problems or questions you would share with a supervisor (or colleagues) to assist you with this case.
7. List areas of content that would be helpful to you in evaluation, planning and implementation of this case.

After you have completed the pre-study section, listen to the total taped program and refer to the evaluation protocols on the following pages.

D. Occupational Therapy Evaluation:*

Activity Configuration Protocol

Client's Name M.S. Therapist D.M.
Date 3/22/76

Activity Configuration Part I

List below what you value most, the things most important to you now and in the near future:

1. My kids - "I wouldn't want anything to happen to them. Don't know what I'd do if my parents didn't take care of them. I'm not a very good mother."
2. A happy family with a good father.
3. Having a nice house and nice things.
4. My religion - "Even though I'm not a very good Catholic."
5. My parents - "They're getting old. I don't want anything to happen to them."
6. Being loved by my husband - "but he probably doesn't want me back."
7. Looking nice - good figure, nice clothes - "If I hadn't gotten fat, my husband wouldn't have left me."
8. Having a good time and being happy.
9. Dating - "I'd like to meet someone nice."

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* Evaluation materials were prepared by Deanne McCraith, OTR, Assistant Professor, Program in Occupational Therapy, Sargent College, Boston University.

OCCUPATIONAL THERAPY EVALUATION

Client's Name M.S.
Date 3/33/76

Therapist D.M.
Context for completing "Several weeks before coming to hospital before my problems."

Activity Configuration Part II

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Morning							
6 - 7 AM	Get up and ready for work; eat breakfast.					Sleep late	
7 - 8							Get up and ready for church; eat breakfast.
8 - 9	Take bus to work.						
9 - 10	WORK						CHURCH
10-11	Coffee break						
11-12							Sometimes help cook dinner
Afternoon						Eat lunch	
12 - 1 PM	Eat lunch					Wash hair	Eat dinner - help with dishes
1 - 2	WORK					Watch TV or go shopping or help with housework	
2 - 3							Watch TV or sleep or Visit girlfriend;
3 - 4	Coffee break						
4 - 5							
5 - 6	Take bus home				Go for drink with people from work		Sometimes do things with parents and children
Evening	Eat dinner						
6 - 7 PM	Help with dishes					Eat dinner	Eat supper
7 - 8	Watch TV or go to bar	Play Beano	Watch TV or go to bar	Watch TV or go to bar	Go to movie or bar	Go to movie or to bar	Watch TV
8 - 9						Sometimes on a date	
9 - 10							
10 -11							
11-12	Go to bed						Go to bed
12-1 AM						Go to bed	
1 - 2							

Client's Name MS

OCCUPATIONAL THERAPY EVALUATION

Therapist D.M.

Date 3/22/76

Activity Configuration Part III

Key for Autonomy #1
A. Have to do it
B. Want to do it
C. Both

Key for Autonomy #2
IG-I want to do this and I think this is good
IN-I want to do this and I think this is not good
OG-Others make me do this and I'm glad they do
ON-Others make me do this and I wish they wouldn't

Key for Adequacy
A. I do this very well
B. I do this well enough
C. I don't do this well enough

Activity Category	Total Hours	Function	Needs Met	Autonomy		Adequacy		Feelings		Comments
				#1	#2		Before	During	After	
1. Sleep	55-60	Health	Physiologic	C	IG	A	Tired	Bliss	Usually good	Sometimes I have trouble sleeping or sleep too much because I'm bored or depressed; like people, but some times too much to do or I daydream
2. Work	40-45	Economic Money	Keeping busy; esteem	A	OG	B (Sometimes C)	Wish I didn't have to go	Sometimes good; sometimes bad	Good	
3. Bars & Movies Beano	20-30	Social	Love and belonging esteem	B	IG IN	B (Sometimes C)	Hope to have a good time	Happy if a good time, depressed if a bad time; sometimes guilty because I should be at home		Don't like to be hassled by men who are drunk or only want sex or make dirty remarks to me
4. Watch TV	12-15	Something to do so I'm not bored		?	IN (IG)	A	Bored	Okay-sometimes sad or guilty		
5. Eat	13	Health	Physiologic	C	IG (IN)	B	Hungry	Good	Good	Guilty if I eat too much and get fat
6. Personal	7	Self-care	Esteem	B	IG	B	Dirty or messy	Good	Good	
7. Housework	2 -3	Care of environment	?	A	ON	C	Dislike Anger	Dislike Anger	Relief	I know I should help more, but I don't like to; maybe I would if I had a nice house
8. Childcare	1 -2 (Sometimes)	"Mothering"	Sometimes love & belonging	C	OG (ON)		Ambivalent, guilty, depressed, sometimes good			
9. Family Activities	1- 2 (Sometimes)	Social	"	C	OG (ON)	C		"		"
10. Church	2	To go to heaven; to be absolved of my sins	Safety, love & belonging	C	OG	C	Tired, (Too early in AM)	Guilt depression fear hope	Sometimes happy Sometimes depressed	

OCCUPATIONAL THERAPY EVALUATION

Client's Name M.S. Therapist D.M.
Date 3/22/76

Activity Configuration Part IV

Notes on discussion with client about her activity configuration:

- Surprised, spend so much time at bars and watching TV - "I really waste my life away."
- "Guess I don't spend much time with my kids or help my parents out. I'm not a very good mother, should have listened to my parents. If my husband wasn't a bum, my life wouldn't be such a mess. Don't know what I'd do if my parents didn't take care of kids. I should, but I don't think I could do it, I'm too mixed up."
- "Wish I had a good husband to take care of me and the kids, then maybe I would be a good mother."
- "Maybe if I had some hobbies or a husband who loved me, I wouldn't be bored and waste so much time watching TV and going out."
- "Wish I didn't have to work, but then I'd really be bored and that wouldn't be good."
- "Looks like a pretty boring life, wish it were different, but don't know what would change it except a good husband. Maybe if my husband came back to me (becomes very tearful)...maybe I'd be better off dead...I guess I'd like things to be better, but just don't know how."

Therapist Summary:

- Use of time fairly well balanced between work, leisure, and ADL pursuits; however, balance depends heavily on parents who assume all household and childcare responsibilities.
- Narrow range of social and leisure activities.
- Strong dependence on others (desire for good husband and parents).
- Little sense of choice or options; passively accepts what is available.
- Externalizes problems.
- Oriented to immediate need satisfaction.
- Concrete, unrealistic perception of relationship with husband.
- Limited insight.
- Although concerned about parents and children, has little sense of responsibility towards them; very ambivalent about childcare and family activities and responsibilities.
- Low self-esteem.
- Oriented toward love and belonging needs with limited resources for mastery and esteem needs.
- Fills time more than planning or using it to meet needs in goal-oriented manner.
- Question suicidal potential.

Recommendations:

- Work on problem solving skills, development of choice and options
- Explore alternatives for expanding range of social and leisure activities

Client's name M.S.
Hospital # 04-07-04
Age 32

Interviewing Therapist D.M.
Date 3/19/76

OCCUPATIONAL THERAPY EVALUATION
GUIDE FOR EDUCATIONAL HISTORY INTERVIEW

1. What is your education? (high school, college, other)

   High school (Catholic Girls' School) Dropped out summer before senior year because became pregnant

2. What were your major interests or areas of study?

   Vocational major - secretarial course

3. What your average grades? Were your grades better in some areas of study than in others?

   Usually B's, honor roll a few times. Didn't do very well in math or science; Did well in English and business courses

4. What did you like best about school?

   Secretarial, business, and English courses; drama club

5. What did you dislike about school?

   Not many friends; people jealous of my figure; sometimes made nasty remarks, usually comments not true

6. What did you think about your teachers? Did you have any favorites?

   Nuns very strict, but nice. Liked English teacher. She helped me write and said I was creative and sensitive (Laugh - Hasn't helped me much with my life; wistful expression)

7. What were your spare time interests during your school years?

   Waitressing to save up for secretarial school; drama club, but couldn't go much because of working; movie magazines

8. What kind of things did you do with friends in school?

   Didn't really have many friends; sometimes hung out at pool hall or drug store
   Didn't date much - all the guys wanted was to "make out" or worse

9. What education did your parents have? Other members of your family?

   None, but worked very hard; wanted me to have an education. I really disappointed them

10. Do you have any future educational plans or interests?

    Maybe to go to secretarial school or beauty school

Other pertinent information (e.g. from school records, family, client, formal testing):
Educational history and concurrent social experiences confirmed by parents.

Summary and recommendations:
- Explore possibility of taking high school equivalency exam
- Explore interests in secretarial or beauty school

Client's name M.S. Interviewing Therapist D.M.
Hospital # 04-07-04
Age 32

OCCUPATIONAL THERAPY EVALUATION
GUIDE FOR WORK HISTORY INTERVIEW

Part I: Current or most recent work experience

1. Where have you been working? How long? Small manufacturing company in same town I live in (electronics); Have been working there 9 months; currently on sick leave. (My boss is getting divorced; it's my fault.)
2. How do you get to work? Take the bus to work. Sometimes a taxi if I oversleep.
3. What kind of work have you been doing? What duties and skills are involved in your work? Have these been the same or have they changed since you've been working at this job? Receptionist-clerk: answer telephone for personnel, bookkeeping, and secretarial offices; answer questions and direct visitors to offices or departments in plant; miscellaneous filing, addressing and stamping mailings; sorting and delivering incoming and outgoing mail. Responsibilities have remained the same.
4. Do you have special training for this job? No, but did this kind of work on my first job - would like to go to secretarial school.
5. What do you not like about your work? Noisy, sometimes too much to do, don't always feel like working, daydream too much; don't like the way some men look at me.
6. What do you like best about your work? Something to do, people friendly, get paycheck; better than assembly line; my boss is nice to me.
7. What is the work environment like? (physical environment, atmosphere, etc.) Noisy; have my own desk off front lobby at entrance to room where secretarial pool, personnel, and bookkeeping offices are - separated by partitions; people friendly.
8. Do you have a work supervisor or boss? Is this person directly or indirectly in charge of your work? Do you do work for persons other than your supervisor or boss? What kind of person is he/she? Boss: a man, office manager; his secretary also gives me work to do. Nice man, but getting divorced; it's my fault. (Why?) "Because I'm divorced and he's nice to me. He talks to me in church, sometimes buys me lunch. He notices other women, not good."
9. How is your work organized? Do you plan what and how you do your work or does your supervisor? Boss or his secretary gives me work to do, e.g., filing, mailings, messages to deliver; do things when given to me. Answer telephone when it rings; answer questions; give directions when people ask; sort mail and put in boxes twice a day - 10AM and 3PM.
10. Do you work alone or with other people? Work mostly alone, although talk to people on telephone and to give directions; also when boss or secretary gives me work to do; sometimes people talk to me when they walk by my desk.
11. What are the people like that you work with? Are you friendly with them? Do you socialize with them outside of your work? People friendly; eat lunch with secretaries in cafeteria and walk to bus with them; sometimes go out for a drink. Don't like the way some men look at me or things they say "All they're interested in is your body."
12. Is your salary adequate? What do you do with the money that you earn? Salary okay. Could make more if a secretary, but need training; use money for movies, bars, sometimes clothes or presents for parents, children. Try to save some to have if don't work and to help parents out.
13. Would you like to keep this job the way it is or are there things you would like to change about it? Job is okay for now, but will probably have to get a new job because of boss' divorce. Would like to be secretary to make more money. Wish I didn't have to work, husband's fault. He's no good.
14. How and why did you choose this job? Looked in newspaper. Parents and priest helped me. (Why chose?) Because I did this work before, sort of like a secretary. Don't like assembly line, although can make more money.

Client's name M.S.
Date 3/19/76

Occupational therapy, work history interview (cont'd.)

Part II Other work experience

1. What other kinds of work have you done? (place, job description, reasons for leaving, etc.)

   a) Waitress - summers, part time during high school - quit because pregnant
   b) Receptionist/clerk, (Longshoremen's Assn.) - after high school, 3-4 yrs; fun - met lots of people, including husband - quit to travel and be with husband - a mistake
   c) Assembly line (electronics firm) - after 2nd child, to earn money - 9 mos; quit to travel and be with husband; also boring, dirty
   d) Salesgirl (dress shop) - after 3rd child, to earn money - 2 mos. - didn't like boss (male); low salary

2. Do you have work skills or special training in addition to those you have already mentioned?

   No

Part III Vocational interests and plans

1. What are or were your parents' occupations? Did they like their work?

   Retired. Father worked for MBTA, mother on assembly line. Didn't have much money. Parents worked hard, always wanted the best for me. Wish I hadn't disappointed them.

2. What did you want to be as a child?

   Movie actress or nurse

3. Did your parents have any influence on your job choice or career?

   They wanted me to go to secretarial school

4. What other persons or events influenced your job choice or career?

   (Laughs) Men, they're no good. I should have listened to my parents and followed teachings of the church

5. Which of the jobs you have had did you like the best? Why?

   1. First job at Longshoremen's Assn. - fun, met lots of people, those were the good days
   2. Current job

6. Which of the jobs you have had did you like the least? Why?

   1. Assembly line - boring, dirty
   2. Salesgirl - customers too picky, boss a "dirty old man," low salary

Client's name M.S.
Date 3/19/76

Occupational therapy, work history interview (cont'd.)

Part III Vocational interests and plans

7. What three jobs or kinds of work do you feel you would be most interested in doing at this present time or in the future?

   1. Secretary in a fancy company
   2. Hairdresser
   3. (Laughs) Housewife, with a good husband - (Aside comment: "Maybe I should be a whore)

8. What are your current work plans?

   Don't know; maybe go to secretarial school. Wish I didn't have to work. Could go back to my job if boss wasn't getting divorced.

Part IV Other pertinent information (e.g. from employer, family, client)

3/12/76 - Phone conversation with employer: Aware of M.S. concern re: his divorce. Feels M.S. is oversensitive and blames herself for others' problems. No realistic basis for M.S. to blame herself re: his divorce. Knows M.S.' family through church. They're good, hardworking people. M.S. has had a rough life. M.S. overly concerned about her appearance and making mistakes, but a conscientious, hard worker. Could take more initiative, be less timid. If M.S. had more secretarial skills, could give her more responsibility and a raise. Would very much like to have M.S. come back to work for him. (Seems concerned re: M.S.' welfare, but no indication of inappropriate employer/employee relationship.)

Part V Summary and recommendations

Summary

1. M.S. functioning competently at current, unskilled, structured job as receptionist/clerk. Conscientious - seems to enjoy job.

2. Inappropriate concerns re: her blaming self for boss's divorce.

3. Question M.S.' motivation for stable employment, although interest in further training is a strength. (Note: Client cooperative and responsive throughout interview; became upset when referring to boss or husband; spoke softly and timidly with nervous smile.)

Recommendations

1. Work placement in hospital with evaluation
2. Strong-Campbell Interest Inventory for Vocational Counseling
3. Explore secretarial training program
4. Vocational counseling with opportunity to reality test current work situation and vocational aspirations, abilities, plans - possible participation in work skills group
5. Return to current job as soon as possible

Client's name M.S.
Hospital # 04-07-04
Age 32

Therapist D.M.
Date 3/17/76 through 3/25/76

OCCUPATIONAL THERAPY EVALUATION

OBSERVATION OF TASK AND INTERPERSONAL PERFORMANCE BEHAVIOR

Observation #1 - Individual structured activity
Date 3/17/76

Observation situation - M.S. selected a small wooden box with an inset "gemstone" design for her project. The kit included directions and materials for setting the gemstones in plasticine and for sanding and finishing the box. M.S. met individually with therapist for one hour to work on the project. Therapist explained that she would like M.S. to do as much of it as she could by herself, but that therapist would answer questions or help if needed.

Task behavior and relationship to therapist - M.S. shyly expressed pleasure at being able to work alone with therapist and cautious enthusiasm for completing the project that she wanted to use for "special things." Before beginning, she stated that she would need losts of help and that she would probably ruin it, but agreed to try to proceed independently upon therapist's encouragement. She first read the directions out loud from beginning to end, sorting out the project parts and imitating the directions as she read. She then proceeded to systematically follow the directions. She frequently checked with the therapist to make sure she was "doing it right" and sought additional support and information when frustrated by a decision requiring judgment or independent problem solving. However, she was able to proceed independently with encouragement or a guiding suggestion from the therapist. She worked meticulously and neatly, attempting to attain perfection on each step by copying the sample as exactly as possible. She completed the project within the hour, except for the application of the second coat of shellac. She smiled with pleasure when praised by the therapist, stating that she didn't think she could do it and that the therapist probably could have done it better.

Observation #2 - Activity group
Date 3/17/76 through 3/25/76

Observation situation - Needlework group with six other women. Group leader available for teaching and resources; however, emphasis is placed on group members teaching and helping each other. Primarily task focused, though social interaction is encouraged.

Interpersonal and task behavior - Although M.S. attended the group voluntarily and expressed interest in learning to crochet, she chose to watch for the first two sessions because she didn't think she could do anything. M.S. participated in the casual conversation of the group, but did not initiate conversation and retired quickly when not directly included, nervously drinking coffee and smoking. She told the group leader that she liked to watch what other people were doing, but that they were so good she didn't think she could make anything. After two sessions with the group, with the supportive urging of the group, M.S. agreed to make a small sample square to learn the crochet stitiches. Although awkward at first, she learned two basic stitches rapidly. She was timid, but responsive and

Client's name MS

Activity group observation (continued)

appreciative of the group members' suggestions and help. At the fifth session with the group, M.S. chose to start making a crocheted vest using the same pattern and color as the woman sitting next to her who had also offered her the most help in learning the stitches. M.S. continued to rely heavily on her friend for help and frequently redid work that she felt was uneven, comparing it to that of her friend. Although M.S. worked patiently, she frequently called herself "dumb" or made comments such as "I'll never get this right." By the end of the week, although still shy and reticent in her behavior, M.S. was joining into the casual conversation of the group and occasionally offering help or support to other group members. She tended to avoid discussing her personal problems, stating that she was "just depressed" or "didn't know" when directly questioned by group members.

E. Post Study Section

Now that you have completed the pre-study self-assessment section and have listened to the tapes and read all of the accompanying written material, assess your own learning by responding to the items below.

1. Would you describe the occupational therapist's role differently after using this study program? If yes, what comments in the tapes or written material helped you to re-define the role?
2. Would you identify or define three (or more) of the critical functions differently now? If yes, how do they differ? Can you identify the component(s) of the program that caused you to change your thinking?
3. How would you change your patient/client evaluation procedures? If you don't think they need to be changed, discuss the attributes of the program you are currently using.
4. Using the same patient/client as before, review the evaluation and treatment plan. Consider how you may modify your plans. Identify the component(s) of this study program that may have helped you to consider changes.
5. Review your list of problems or questions from Item 6 of the pre-

study assessment. Have any of the problems been resolved or any of the questions answered? Are there additional problems or questions that you want to add to the list?

6. Identify how you can resolve the problems and/or answer questions for yourself. How would you use a peer supervision session to assest you? What types of resource materials materials would be helpful?

F. Evaluation of Self Study Program

Please complete this form and return it to AOTA Office of Continuing Education. Your responses and comments will be used to assess the value of the program and will aid in the design of future study packages. It would be helpful if you attach copies of the pre and post study self-assessment sections for our consideration.

I. Personal Information (you need not give your name)

Highest academic degree________ Date earned__________

Date of completion of basic professional education _________

Number of years of professional occupational therapy experience________

Are you supervised by an OTR?________If yes, briefly describe the supervision received (i.e., how often what types of issues are discussed, etc.)____

____

____

Briefly describe the occupational therapy program, include number of staff, number of patients/clients seen, relationship to other departments.____

____

2. Self Study Program

How long did it take you to complete the program, including the pre and post study sections? ____________________

Using the scale below, indicate the relative value of each part of the program.

	of no value 0	1	2	3	4	5	very valuable 6
A. Pre study Section							
B. Team conference (tape)							
C. Occupational Therapy evaluation. 1. Taped presentation							
2. Written protocols							
D. Taped peer supervision							
E. Written statement of Role & Function of an Occupational Therapist as a Mental Health Practitioner.							
F. Post study section							

Did you use this program alone or did you collaborate with a colleague or group of colleagues? Briefly describe how you used the program.

Describe as specifically as possible how this program was helpful (or not helpful) to you.

List as specifically as possible what you learned by using this program.

Would you recommend this program to colleagues? If not, please suggest modifications that improve the value of the program.

Has this program study led you to identify the need for further study? If yes, list topics and/or areas of study needed.

Have you used the audio-taped study programs previously? How does this one compare with others?

If you disagreed with the content, and/or approach to patient/client care demonstrated, please discuss your point of new.

Please attach any additional comments.

Thank you.

APPENDIX A

The Case-Study Self-Assessment Instrument

The American
Occupational Therapy Association, Inc.

Dear AOTA Member,

Two years ago American Occupational Therapy Association was awarded a contract from the Department of Health, Education and Welfare to develop a continuing competency program. The first part, Definition of the Role and Functions and Standards in five specialty areas (Mental Health, Physical Dysfunction, Arthritis, Stroke and Developmental Disabilities) was completed recently. The project staff, in the second part will be designing a continuing education program in one of the five areas. Mental Health was selected because of the many requests from members for continuing education in Mental Health. The New England-New York region was selected for survey because of the high concentration of occupational therapists practicing in Mental Health.

The project staff and task force members are asking for your assistance in helping to define the continuing education needs of the membership. This request should not take more than an hour of your time. Your participation is essential to the success of the program, so please consider helping us.

Enclosed are three case examples, select one and use that to answer the accompanying questions. If none of the cases resemble the types of clients you treat, you may present (briefly) a case of your own. Also, if there are members of your staff (or friends) who have not received this request, please photocopy the material and encourage them to participate.

Upon receipt of your response, I will mail to you a copy of "The Role and Functions of an Occupational Therapist as a Mental Health Practitioner" and the treatment plans of the three cases presented. (These have been prepared and reviewed by several occupational therapists throughout the country.) Be sure to include your name and address on the enclosed stamped envelope, not on the response sheet.

If you have any questions, please call or write to me.

Sincerely,

Diane Shapiro

Diane Shapiro, OTR
Principal Investigator, Part II
Continuing Competency Contract

DS/js
2-3-76

6000 Executive Boulevard Rockville, Maryland 20852 301—770-2200

INSTRUCTIONS - Please select a case, preferably from the three enclosed. Consider the realities of your facility in your answers and discussion. Please present what you actually would do with such a client. You are asked to predict the client's response. Use your own judgment and experience based upon the case information available. Attach additional pages, copies of evaluation forms and anything else that you wish.

A copy of the "experts" response to the cases and questions will be sent to you upon receipt of this completed survey. A summary of all participants responses will be sent later.

Do not enter your name on this form.

1. Indicate case selected. (If substitute, please attach case description)

2. Briefly describe facility.

3. Screening - Evaluation
   A. What, if any further information would you obtain, and why would you need it.

   B. If you answered yes to the above. Predict the client's response(s) to your inquiry (ies).

   C. How would you evaluate the client? What instrument (s) would you use? And why? (Please attach evaluation protocols, if available.)

D. Predict client's responses and outcome of evaluation, present (briefly) all findings.

4. Present Treatment-Program Implementation Plan.

5. Describe predicted outcome to Treatment-Program Implementation.

6. Discuss follow-up or aftercare plans.

7. What type of continuing education would help you with client case?

CASE #1

Identification L.C. is a 35 year-old white female. She was admitted to an inpatient service two weeks ago via a petition (by father) for commitment. Admitting diagnosis: schizophrenia, catatonic type.

Current condition Upon admission L.C. was mute but would respond to direct request. Her posture was rigid, she stood erect with arms held above her head, eyes fixed on ceiling, palms forward, and fingers extended and abducted maintaining this position for several hours. She refused oral medication and food but did not resist IM medication (Haldol 5mg IM tid). She began to talk (respond to questioning) and maintain this position for only brief periods of time (10 to 15 minutes.) On the seventh day she began eating (vegetarian diet) and taking medication orally. Condition continued to improve throughout the second week. She attended all activities, accounted history to staff and expressed interest in future planning.

Events Precipitating this Admission L.C. was living in a religious group (past 5 months) with her 8 year-old daughter. Ten days prior to admission, she began fasting and maintained the position described above. Friends at the group called her father, whom she had not had any contact with for the past 8 years. Father saw her and took her directly to the hospital. The daughter is now staying with the father, his wife and their two teenage children.

History L.C. was only child of that marriage. Parents divorced when she was 7 years-old. Father remarried. L.C. lived with mother in suburban community. Mother died during heart surgery 3 years ago. She completed one year of college, was an average student. Began using a variety of drugs, including heroin but was not addicted. She married at 22 to a 26 year-old man she had known for 5 years. L.C. worked as a receptionist for the first 2 years of their marriage. Together they traveled throughout Europe and the States working at resorts for brief periods of time. Husband was a heavy drug user. Daughter was born when L.C. was 27. About 2 years ago L.C. met an older woman in a park who convinced her to give up drugs and join a religious order. The woman converted L.C. from Judaism to Christianity and introduced her to a religious community that accepted L.C. and the child. She has not seen her husband since.

During the past 2 years L.C. has been in 4 different religious groups and has been hospitalized twice. Both times the circumstances were similar to the current illness.

CASE #2

Identification V.C. is a 32 year old black male and was admitted voluntarily to an inpatient service 4 days ago. After 24 hours status was changed to detention. Admitting diagnosis: (1) schizophrenia, paranoid type (2) alcoholism, acute.

Current Condition Upon admission, V.C. was agitated and hyperactive. He stated that he came to the hospital to protect himself from his girlfriend who was going to kill him. He was treated with Mellaril 400 mg qid. Within 24 hours he requested to leave and became violent and abusive to staff, a detention was ordered. He is now on close nursing supervision, is cooperative and morose. Diagnosis changed to (1) schizophrenia, chronic undifferentiated type and (2) chronic alcoholism.

History V.C. is the youngest of 4 siblings and the only male child. He was raised in a small southern town. Father, a factory worker, was murdered 4 years ago. Mother worked in a beuty shop since V.C. was 10 years old. Three older sisters are all married and living in northeastern cities. V.C. was a good student, he completed college at 21 and has been employed as an engineering assistant since then (several different jobs, none lasting more than 1 year). He married at 24, was divorced at 29. Since his divorce, he began drinking and has not had a permanent home. He was treated in an outpatient program primarily for alcoholism and has not worked for past 18 months. The woman he is currently living with is 16 years old, is a prostitute, and supports him.

CASE #3

Identification S.K. is a 24 year old whit male who was voluntarily admitted to a general hospital emergency room. He stayed for one night and was referred to a community mental health program the following day. Admitting diagnosis: anxiety neurosis.

Current Condition S.K., upon admission to the CMHC was oriented and extremely anxious. Pulse rate was high, speech was pressured, hands were clammy, pupils dilated. He was not on medication and had not eaten for several days. He stated that he was fearful of something but could not identify the source or relate it to any previous experiences. He was cooperative and gave a complete history.

Precipitating Events 3 weeks ago S.K. had an "anxiety attack" while driving to his family's farm for a weekend visit. His wife and 19 month old daughter were in the car. He could not breathe, vision was blurred and his left leg became painful and cramped. His wife drove them home. He refused to leave the home and wrote a letter of resignation to his boss. The symptoms persisted for the three weeks. He finally admitted himself to the hospital without discussing this with his wife.

History S.K. was only son of a career naval officer and wife. Parents divorced 10 years ago, father retired shorthly afterward. S.K. went a total of 17 schools and was a consistenly poor student. He joined the army at 18 and served in combat in Vietnam. Toward the end of his duty he received a shrapnel wound in his left leg. It reguired surgical removal. There was no residual functional deficit. Following his discharge, he married and began working for his father-in-law's construction compnay as a site foremen. He had long periods of anxiety caused by "flashbacks" of combat experiences. He was hospitalized in the VA for 2 months and treated with valium and psychotherapy. He has be asymptomatic for the past 2-1/2 years. About 4 weeks ago he received a promotion and a raise. His wife has a full-time job, a neighbot cares for the child during the daytime.

FOLLOW-UP MATERIALS

Some General Comments

Given the concept that one evaluates for behaviors (or feelings) that you treat for, it is necessary to define a general frame of reference for approach to the client prior to evaluation. If for example, the therapist ascribes to a developmental frame of reference, he/she would assess the client based upon some predetermined behavioral (and/or emotional) developmental hierarchy.

All information deliberately obtained should be directly related to behaviors (or feelings) that the occupational therapist can (and does) treat. For example, occupational therapists do not assess the client's body temperature because we are not trained to effect a change in body temperature. The client's functional and dysfunctional behaviors should be clearly defined by the evaluation and stated in the report.

Program implementation plan should follow the same frame of reference as the evaluation program. If the evaluation "uncovers" the client's specific behavioral dysfunction, the treatment plan must specify how the therapist will attempt to modify those behaviors.

COMMENTS FROM THE "EXPERTS"

Case #1 - L.C.

We will assume that the therapist will use an acquisitional frame of reference (Anne C. Mosey, Three Frames of Reference for Mental Health, Charles Slack, Inc., Thorofare, New Jersey, 1970). This means that the goal of treatment will be the client's acquisition of the specific skills defined by client and therapist as necessary for adaptation in the expected environment. The evaluation will consist of a discovery of the client's existing skills, a description of the expected (realistic) environment and an estimation of the skills necessary for adaptation to that environment.

Screening-Evaluation

Additional information. All of the following information is needed to define the expected environment, L.C.'s current skills, and those skills needed for adaptation to the expected environment.

1. What sources of income are available to L.C.? Will she need to work, pay rent, pay for child care? Will (can) father contribute to income and/or provide housing and child care?

2. Are L.C. and the father (and his family) agreeable to living together? On a temporary basis? Could this be a mutually healthy situation? What other living arrangements could be considered?

3. What is the child's emotional status? What kind of living (and school) arrangements would be best for her?

4. Can (and should) the husband be involved in any of the planning?

5. What work (employable) skills does L.C. have? Is she capable of learning new skills? Is she motivated to work?

6. Can L.C. care for herself? Does she need to learn any new skills to do so?

7. Does she want to care for her child? Can she? Does she need to learn any new skills to do so?

Client's responses. L.C. has expressed an interest in future planning and is now responding to questioning, so many of the above questions can be discussed with her. Assuming that a social worker is also involved in her treatment and has had contact with the father and L.C.'s child, he/she can also provide information.

1. No source of income, other than disability or welfare. Father cannot afford to contribute significantly to support L.C. The father, his wife and their children are reluctant about having L.C. live with them permanently, but would consider a temporary situation.

2. L.C. does not want to live with her father at all, and would like to return to Florida (where the religious community is), but not join the commune again. She does not want to live alone, with her husband or with anyone else she knows. She would consider a foster family, if that could be arranged.

3. The child (as reported from social worker, L.C.'s father's wife who is currently caring for her) is "difficult". She refuses to go to school, cannot read or write and will not play with other children. She is disruptive to the household, refuses to eat and cries frequently. The father (L.C.'s) has considered taking her to a psychiatrist, but L.C. is opposed to that. L.C. says that she loves the child and wants to care for her. She recognizes that the child needs a stable environment, discipline and school and is willing to try to provide that for her.

4. L.C. does not want any contact with her husband. She does not see the need for a legal divorce now.

5. L.C. said that her job as a receptionist, several years ago, was satisfying and she could do that again. Since then, when she has needed money she worked as a waitress, dishwasher, chambermaid and babysitter, but hated all of those jobs. She would like to learn how to type and take stenography. She said that she learned new things easily when she was interested.

6. She can care for herself, but hasn't been doing so since she's been ill. She does not see her poor nutrition (or the child's) as a problem. She doesn't think that she would even voluntarily take medication if prescribed.

7. She thinks she can care for her child, but has neglected her since she has been ill. Their "casual" lifestyle has been detrimental to the child, but L.C. believes that can and will change.

Evaluation. L.C. will need to work, care for child and herself. An OII (Ohio Interest Inventory) will be administered as well as a battery of sample activities that assess the ability to follow written and verbal directions, attention to detail, neatness and use of common tools (pencil, ruler, sewing needles, scissors, etc.). An ADL (activities of daily living) evaluation will also be administered. This will include child care, personal hygiene, meal planning and preparation, housekeeping, shopping (budgeting, etc.), laundering and clothing repair.

Evaluation Findings

L.C. is able to comprehend both written and verbal directions and can complete complex (multistep) tasks. Her performance on an evaluation activity was excellent. The work was accurate, she approached the task in an orderly fashion and the product was satisfactory.

The results of the OII indicated an interest in clerical-type jobs. She does not like working with other people, but needs structured supervision. L.C.'s greatest difficulties, at this time, are in the areas of personal and child care. She is poorly disciplined, realizes that she must attend to hygiene and nutrition, especially for the child, but prefers to ignore these needs. She stated that, as a child, her mother nagged her about these issues, but then always took care of them for her. She would like her daughter to be more independent, and thinks that she will, if they are not made an issue of. L.C. preferred commune type living because "other people take care of all those things". She says that she knows how to cook and shop but just doesn't want to do it.

Discussion: There is no cognitive impairment interferring with L.C.'s ability to care for herself and her child. She could readily learn to keep a home, if she were motivated. With some training in vocational skills, she could get a job. Her ability to actually care for her child properly is questionable.

Motivation for independence is the crucial issue in L.C.'s treatment. This should be dealt with in psychotherapy as well as in the activity program.

Treatment-Program Implementation Plan. As mentioned above, an acquisitional frame of reference will be used in planning L.C.'s treatment program. The following skill - instruction activities will be offered. L. C. will be asked to select the sequence of participation.

1. Clerical Skills Group. (Three afternoons a week) The group consists of instruction in a variety of office skills, such as filing and typing. Within 3-4 weeks, L.C. should be able to type 20-30 wpm and do a variety of other office skills.

2. Work Skills Group. (Three mornings a week) These group members do actual jobs (contracted from offices within the hospital). It is intended to teach clients job skills such as accepting (and giving) supervision and instruction, working under pressure of deadlines, collaboration, punctuality, proper dress and other work habits.

3. Living Skills Group. (Two mornings a week) In this group, participants are taught activities of daily living.

4. Mothers' Group. (One hour a week) This is primarily a discussion group for women with children. Child care, nutrition and discipline are discussed by members.

In addition, the occupational therapist will see L.C. for brief periods 2-3 times a week to evaluate progress and review plan.

Predicted Outcome. L.C. selected participation in the clerical and work skills groups only. She agreed to "sit in" on the mothers' discussion group - but announced that she wouldn't add anything to the discussion.

Her involvement in the groups helped her to learn marketable job skills. She could (after 2 weeks) type 30 wpm. and began learning shorthand. She and the group leader discussed continued study and considered joining a secretarial program after discharge. The Vocational Rehabilitation Administration (VRA) could possibly support this.

She continued to refuse the living skills group, but her personal appearance has improved. L.C. thinks that she would like to move to Florida, live in a foster home (if possible) with her child and go to school. The social worker is looking into the possibility of this. L.C. has been referred to a vocational counselor and a VRA representative.

Success in job performance has helped to motivate her toward independence. Clearly, she could not care for the child, without assistance, but may be able to after several months or perhaps longer.

Discharge - After Care Plans. Before she leaves the hospital (total stay of 5 weeks), she will be referred to an outpatient occupational therapy program in Florida. A foster home will be arranged and application to a secretarial school will be submitted. Her child will be staying with L.C.'s father until L.C. is settled in Florida. When she comes back to pick up the child (about 4 weeks) she will be seen by this occupational therapist for an evaluation of progress. Insurance, disability, VRA and the father will cover the expenses. Continued psychotherapy and medication is recommended.

Case #2 - V.C.

This is a state-supported training facility. Clients usually stay for a maximum of four months and then are either discharged or transferred to another longer term hospital. All clients are evaluated by an occupational therapist. The treatment approach varies, depending upon individual needs, but a standard evaluation procedure is used.

Screening-Evaluation

The possibilities must be considered that V.C. will need to provide a stable environment for himself and continue taking medication. His ability to obtain and maintain a job and care for himself needs to be determined.

V.C. would probably not be cooperative in an interview (because he is resisting hospitalization). He should be assigned to an evaluation group and encouraged to participate in activities.

V.C. will be given the standard occupational therapy evaluation that consists of two individual projects (one with oral direction, one with written direction), and one group project. These are designed to assess the ability to perform tasks, use tools, follow directions, set priorities, make decisions, collaborate with others, accept direction and supervision, and attend a various stimuli. A work-play history is taken and a structured questionnaire is given to assess self-care abilities and attitudes.

Evaluation Findings

V.C. was not talkative, but did whatever he was told to do. He was poorly coordinated and clumsy and had great difficulty doing any of the activities. He suggested that the physical awkwardness was caused by the medication and his sleepiness. He understood the directions, but couldn't execute the activity. He will be assigned to leisure time activities of his choice for several days until he is able to participate in the evaluation program.

Reevaluation - Seven Days Later

This time V.C. was able to complete the evaluation without any difficulty. His work was a bit sloppy, but correct. He quietly ignored other people and did not voluntarily participate in the group project. He did whatever was assigned to him by the other clients.

V.C.'s work history is chaotic. He was fired from jobs because of absenteeism and tardiness. When he worked, he did a good job and liked it. His drinking interfered more than any lack of skill. When drunk, he would neglect himself, not eat, bathe, etc. During the past several years his leisure time consisted of drinking. Prior to that, he engaged in sports and really enjoyed them.

Treatment-Program Implementation Plan. If V.C. can be maintained on medication (he agrees it is helpful) he could probably work. He should be involved in a local A.A. group prior to discharge. In occupational therapy he will be assigned to a full-time work skills program to help him "practice" working. He will be required to be punctual. In the evenings he will be assigned to sports groups. A referral to a vocational placement counselor will be made.

Predicted Outcome. As long as V.C. is not drinking and is taking medication, he will probably enjoy the work and sports groups. The problem will be motivating him to maintain medication and sobriety after hospitalization. A supportive living arrangement should be sought. He should be discharged as soon as he gets a job and a place to live. Dependence upon A.A. should be encouraged. Living with or near another member of A.A. may be beneficial and should be considered.

Discharge-After Care Plans. V.C. should be seen weekly for medication check-ups and a review of his status. His schedule should be active. Referral to a community-evening sports program should be made.

Case #3 - S.K.

The community day center that S.K. was referred to treats clients for three weeks in an "intensive" all day program. After three weeks, the clients are either discharged or are assigned to individual group (or family) therapy twice weekly for a maximum of one year. Most clients received medication and are maintained on it (when necessary) for an indefinite period of time.

The theoretical approach used is one of a combination of psychodynamic interpretation and applied behavior modification. During the three week program, the staff help the client to "uncover" the factors that were causative (to current illness). Instead of "working through" the conflicts, as would be the approach in a long term psychoanalytic oriented psychotherapy, the client is taught via behavior modification how to minimize and cope with conflictual situations. The staff believes that once behaviors are changed, feelings will then change.

Screening-Evaluation

Additional Information. The cause or causes of the recent "anxiety attack" need to be determined so that the causative events could be avoided in the future. This information could be obtained in an interview with S.K., activity evaluation or from reports of other staff.

Client's Responses. Following individual interviews with S.K. and his wife and a review of his previous hospitalization (about 2-1/2 years ago) records, the staff (psychiatrist, psychologist, occupational therapist, social worker, and nurse) met to formulate a plan of evaluation. In an interview with the occupational therapist, S.K. stated that he didn't understand why he had an anxiety attack. The only conclusion he could reach was that the pain in his leg elicited the fear, which then brought about the anxiety symptoms.

The staff agreed that potentially uncomfortable situations such as increased responsibility caused S.K. to have "flash backs" to his combat experience. The resultant anxiety overwhelmed him and thus prevented him from participating in the uncomfortable situation.

The goal of evaluation will be to assess the situations that potentially cause anxiety. Each staff member will approach this differently and will then formulate a consistent treatment program.

The occupational therapist will use a battery of projective activities to include drawing, clay sculpture, and a collage. S.K. will also be given a complete evaulation to assess his skills. This will be done to rule out the possibility of skill deficits contributing to concurrent condition.

Outcome of Evaluation. S.K. completed six drawings and one clay sculpture. At first he was disturbed by drawing since he felt inhibited by his lack of talent. The therapist structured the task by asking him to draw a farm scene, because of his hesitancy to draw. He rapidly sketched a barn, silo, and a house and said it meant nothing. Later he drew another scene with a dead farm animal. He recalled his grandmother's rifle collection and feared seeing them. All of his projects had a theme of violence to them (his interpretation).

Evaluation Report. After a reluctance to participate in the projective evaluation, S.K. drew several scenes; all had symbols of death and/or violence in them. He described the symbols as more violent than they appeared to the therapist. S.K. was able to connect the symbols to his combat experiences and with some suggestion by the therapist could see that the fear allowed him to avoid functioning. He didn't understand why he would want to avoid visiting his mother and grandmother.

At the staff evaluation conference, all members reported similar findings. The psychologist suggested that perhaps S.K. was afraid that he might kill his mother. He was angry with her and could have lost control and shot her with one of his grandmother's rifles. By extension of that reasoning, he may be frightened of his anger and its possible harm to others. S.K. said that when in Vietnam, he needed to feel rage when he fought - combat training encouraged that. Since then, he has not gotten (or felt) angry at anything.

S.K. demonstrated no skill deficits. He performed exceptionally well in all tasks.

Treatment-Implementation Program. The goal of treatment will be to help S.K. identify situations (experiences and feelings) that cause him to feel angry, then teach him how to handle the situation. Individual, group, and family therapy programs will be assigned. S.K. will also be allowed to select a variety of activity groups led by the occupational therapist. The activities will be oriented to interaction with other people and will include discussion of the interaction. S.K. will be asked to identify his feelings and plan his responses. (Therapist will assist in the planning, not the identification) Appropriate planning and implementation will be verbally reinforced.

Predicted Outcome Plan. S.K. will likely have trouble seeing his annoyances and anger with other people. With much support and encouragement from the entire staff and his wife, he should be able to identify some of his feelings.

Before his discharge from the three week program, the staff will suggest that S.K. visit his mother either at the farm or at his own home.

Hopefully, he will feel comfortable seeing his father-in-law. It is possible that he felt overwhelmed by the additional responsibility imposed by his promotion and was angry that his father-in-law caused it. Though this need not be discussed with the father-in-law, S.K. should be able to recognize the possibility of anger and still maintain a working relationship (not feel as if he would harm him).

Discharge-After Care Plans. S.K. will be seen twice weekly in inidividual psychotherapy. The occupational therapist does not see the need for continued occupational therapy because a return to work would provide the situations necessary for discussion in psychotherapy.

APPENDIX X111

AOTA CONTINUING EDUCATION

PROPOSED PLAN

AOTA CONTINUING EDUCATION
PROPOSED PLAN

Introduction

The American Occupational Therapy Association (AOTA) has elected not to develop a Continuing Education Unit program because in most cases the accrual of units is only indicative of attendance at a program, and does not guarantee that relevant learning has occurred. Traditional continuing education programs are often workshops or seminars conducted in large cities. To attend, members must leave their jobs for several days and spend considerable amounts of money. Therapists who work in small departments, rural areas and those with family responsibilities are rarely able to attend. These are the members, who because of professional isolation are frequently most in need of formal continuing educational experiences. This program proposes a method of bringing trained educational counselling, and experiences to all the American Occupational Therapy Association members.

The term "continuing education" commonly means advanced but not academic or degree oriented education in a specific profession or trade. Many professional, extra-job related experiences fall under this category, such as in-service programs, and professional conferences. Many of these programs are relevant to some therapists but often the scope of the presentations are either too general or at too high or too low a level for many of the participants. The therapist has no way of evaluating the worth (to himself/herself) until after the time and money have been invested.

We propose to divide the categories of continuing education based upon the following expressed needs of the membership:

1. General basic review programs. These programs will be designed for therapists who have been absent from practice for several years and wish to return. The programs will present a review of basic knowledge with a focus upon recent contributions to the profession.
2. Basic speciality programs. These programs will be designed for recent graduates of basic professional programs (B.A. or M.A.); therapists who are returning to practice after an extended absence and have completed the general basic review program, and who wish to specialize in a specific area of practice. Experienced therapists wishing to change their area of speciality are also included in this category. These programs will focus upon the basic principles of the various speciality areas.
3. Advanced speciality programs. These programs will be designed for therapists who have demonstrated advanced competency in a speciality and wish to acquire additional related knowledge or experience within that speciality.

4. Role related programs. These programs will be designed for therapists wishing to change or assume a new role as an occupational therapist. For example, therapists who wish to become supervisors in addition to or instead of their responsibilities as primary care practitioners would need basic educational experiences in supervision.

Since a committment to continuing education should be each professional person's ongoing responsibility, continuing education programs should be a part of the therapist's daily work activities. Learning materials and programs, as well as educators should be readily available to the therapist. These educational experiences should not interfere with, but should enhance the therapist's practice. The American Occupational Therapy Association proposes to train regional continuing education counselors-coordinators and to establish a variety of programs throughout the country designed to meet the specific needs of members within their own home and working environments. Since individuals have different styles of learning and priorities, a variety of types of experiences will be developed. The four categories outlined above will be used as a guide for the regional programs. Such consistency will permit a national sharing of programs and the maximal use of experiences and materials prepared by regional programs.

It is the intent of this proposal to:

1. Develop and conduct regionally-based continuing education programs

throughout the United States and Puerto Rico.

2. Identify and train regional coordinators who will eventually be employed by each affiliate association and located within college and university occupational therapy curricula.
3. Develop a system of coordination of the regional programs within the AOTA national office.
4. Develop a variety of learning materials that would be available to each of the regions.

Method

1. The American Occupational Therapy Association Office of Continuing Education and a committee of educators and practitioners will develop guidelines for programs in each of the four categories. A final draft of the guidelines will be reviewed by a larger group of occupational therapists and then submitted for approval to the AOTA Standards and Ethics Commission.

2. Individuals within each affiliate will be appointed by the affiliate president to voluntarily plan for implementation of the programs. The plan will be based upon the guidelines and the needs of the regional members. Continuing education needs will be determined through the use of a standard assessment survey and through information submitted by therapists who are participating in quality assurance, chart audit, patient care evaluation programs.

3. A survey and evaluation of existing ongoing continuing education will be conducted. The successful programs will be identified and assessed for the applicability in other regions. If applicable, they will be "packaged"* and filed in the AOTA national office. The group, region or individual who develop the package will loan (or sell) it to AOTA who will advertise the program and then administer the rental (or sale) of it to the regions requesting the package. The cost will be shared by AOTA and the region. The profits made by the region will be shared by the region, the creator of the package, and AOTA. AOTA's share of profit of packages developed within regions is intended to cover the cost of administration.

4. Once the continuing education needs of the members and existing programs are assessed and made available, additional packages will be developed either by the regions with financial investment, if necessary, from AOTA, or other outside sources. These packages will be loaned to AOTA for distribution. In some instances, AOTA may independently develop the packages. This will be encouraged so that direct profits can be used to support the program.

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* Package refers to learning materials, including audio and/or audiovisual cassettes, programmed instruction materials, films, book, course outlines, suggested faculty, and specific education methodologies. An attempt will be made to publish or copywrite the materials to protect the author or developer.

5. As the regions increase their financial base through sale or rental of packages, they will employ a trained continuing education counselor-coordinator. This person will be available to all AOTA members residing within the region for continuing education advisement and referral to programs and resources. A small fee for service may be required to supplement support. It is recommended that this person be located at an occupational therapy university program whenever possible because of the availability of resources.

Discussion

1. Many of the packages developed may be useful to non-occupational therapy professionals. Every attempt will be made to encourage wider use of the materials whenever possible. Likewise, other professional groups offer programs that are worthwhile to occupational therapists and efforts will be made to incorporate those programs with AOTA's. All programs advertised and administered by AOTA will be subjected to the same assessment of standards.

2. The issue of recognition of participation has not been addressed in this proposal. Ideally a professional should not need formal recognition for keeping up to date and/or improving skills and knowledge. It is in a sense one's professional responsibility. The accural of units is a weak award

since it does not necessarily identify an individual as skilled or knowledgeable.

AOTA is designing a recertification program to assess competency of members through a chart audit evaluation of job performance. Participation in a chart audit, quality assurance program may become a part of future recertification requirements. Evidence of participation in continuing education will not be the main requirement since continuing education is viewed as process through which a therapist can obtain competency, not an end in itself.

AOTA, in addition, has a mechanism of peer recognition and has recently proposed to refine and expand it. This too is seen as separate from continuing education.

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